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F 000	INITIAL COMMENTS	F 000		

Amended 09/16/15

A Recertification Survey was initiated on 08/11/15 and concluded on 08/14/15. The facility was found not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "F".

In addition, an Abbreviated Survey was initiated on 08/11/15 and concluded on 08/14/15 to investigate complaint KY23660. The Division of Health Care unsubstantiated the allegation with no deficiencies cited.

Upon Supervisory review the survey was reopened on 08/21/15 with Immediate Jeopardy identified on 08/21/15 and determined to exist on 07/17/15 at 42 CFR 483.20 Resident Assessment (F281); 42 CFR 483.25 Quality of Care (F323); and, 42 CFR 483.75 Administration (F514) at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 08/21/15. An Extended Survey was conducted on 08/27/15 and concluded on 08/29/15.

On 07/17/15 the facility staff transported Resident #26 in a facility van from another nursing home. The staff failed to secure the resident via all available safety restraints. The resident's three (3) wheel scooter tipped over during transport and the resident fell from the scooter. The resident was subsequently transferred to the Emergency Room on 07/17/15 with a diagnosis of Subdural Hematoma and expired on 08/01/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/30/2015

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F 000	Continued From page 1 from complications. The facility failed to complete a Situation Background Assessment Recommendation (SBAR) form for Resident #26 until the resident was sent to the hospital. The facility also failed to document the fall on the twenty-four hour report; therefore, nursing staff was not all aware of the fall or the details related to the fall the resident sustained. An acceptable Allegation of Compliance (AOC) was received on 08/28/15, alleging the removal of Immediate Jeopardy on 08/27/15. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 08/27/15 as alleged prior to exit on 08/29/15, which lowered the Scope and Severity to a "D" at 42 CFR 483.20 Resident Assessment (F281), 42 CFR 483.25 Quality of Care (F323) and 42 CFR 483.75 Administration (F514) while the facility develops and implements the Plan of Correction (POC), and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. Additional deficiencies were cited during the Recertification/Abbreviated Survey with the highest scope and severity of a "F".	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 241		

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and facility policy review, it was determined the facility failed to ensure staff provided care in a manner that maintained dignity for two (2) of twenty-six (26) residents, and one (1) of seven (7) unsampled residents, (Resident #4 and #6 and Unsampled Resident A) Observation revealed the residents' bodies were exposed during the provision of care.

The findings include:

Review of the Resident Rights Policy, revised March 2010, revealed each resident should be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment.

1. Resident #6 was admitted on 07/22/15 with a diagnosis of Cerebrovascular Disease, Hypothyroidism, Metabolic Encephalopathy and Chronic Heart Failure.

Review of Resident #6's Admission Minimum Data Set (MDS) Assessment, dated 07/22/15, revealed Resident #6 had a BIMS score of ninety-nine (99) which meant the resident was not interviewable.

Observation of Resident #6's Gastrostomy tube (G-tube) care, on 08/03/15 at 11:09 AM, revealed Resident #6's window blinds were open when Registered Nurse (RN) #4 exposed Resident #6's breasts to clean Resident #6's G-tube site.

Interview with RN #4, on 08/13/15 at 11:25 AM, revealed she should have closed Resident #6's blinds. RN #4 stated some of the visitors park in the back parking lot and this could allow viewing into the room and cause embarrassment for the

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resident.

Interview with the Assistant Director of Nursing (ADON), on 08/14/15 at 4:30 PM, revealed keeping a resident's window blinds open could be a dignity concern. The ADON stated it could make the resident feel embarrassed or ashamed.

2. Observation, on 08/12/13 at 8:35 AM, during the morning medication pass on the 200 Hallway, revealed Licensed Practical Nurse (LPN #14) entered Unsampled Resident A's room to administer the resident's dose of insulin. Unsampled Resident A was in Bed-1 closest to the door that opened into the hallway. The nurse did not close the resident's door and after verifying the correct resident and medication dosage, she asked Unsampled Resident A to lift his/her shirt, exposing his/her abdomen, and administered the sub cutaneous injection without first closing the resident's door to provide privacy.

3. Observation on 08/12/13 at 8:35 AM, during the medication observation, revealed Resident #4, was reclining in bed and was receiving morning care provided by Certified Nursing Assistant (CNA) #10. Resident #4's abdomen/chest was partially exposed and his/her legs were partially uncovered. The CNA did not pull Resident #4's privacy curtain when LPN #14 and the Surveyors entered the room to observe the insulin injection for Unsampled Resident A. Review of the facility's BIMS list, not dated, revealed the facility assessed the resident with a score of 15, meaning the resident was interviewable.

Interview, on 08/13/15 at 8:16 AM with CNA #10,

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F 241	Continued From page 4 revealed she typically assisted Resident #4 with morning care which included bathing, oral care, shaving, catheter and colostomy care. CNA #10 stated when the surveyors and the licensed nurse entered the room, she was washing the resident's face, and was to apply his/her deodorant, cleanse his/her hands and provide perineal and colostomy care. CNA #10 stated she had pulled Resident #4's privacy curtain when she began providing the care, but she stated Resident #4's roommate, Un-Sampled Resident A, had pulled the curtain back as he/she was returning from the restroom. CNA #10 stated it was important to ensure that Resident #4's privacy and maintain his/her dignity. CNA #10 stated Resident #4 was a very private person, and did not like people to see his/her colostomy. Interview, on 08/14/15 at 4:25 PM with the ADON, revealed staff should ensure the privacy of residents when providing care and this should be done by pulling the privacy curtain between residents' beds in double rooms and closing entry doors from the hallway. The ADON stated exposing a resident's abdomen when providing an injection, and not closing the entry door from the hallway, could be a dignity issue for the resident.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by:	F 253		

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Based on observation and interview, it was determined the facility failed to ensure the environment was maintained in good repair for three (3) of four (4) nursing units. The 100 Unit had multiple rooms with paint chipped off the door frames, and paper towel dispensers were found empty. The 200 Unit had splintered wood on the fire doors and paper towel dispensers were empty. The 300 Unit had two (2) soap dispensers that were empty.

The findings include:

Interview with the Resident Council, on 08/11/15 at 3:00 PM, revealed three (3) of fifteen (15) residents who attended the group meeting voiced the facility never had soap and would have to utilize their own.

1. Observation of the 100 Unit, on 08/12/15 at 9:18 AM, revealed in room 333, when the nurse attempted to wash their hands, the soap dispenser was empty. Licensed Practical Nurse (LPN) #7 had to leave the room and get a portable bottle of hand soap.

Observation, of the on 08/13/15 at 8:56 AM, during the morning medication pass on the 100 Unit, revealed the paper towel dispenser in Resident Room 103 was empty and the licensed nurse had to cross the hall to Resident Room 102 to obtain a paper towel for drying her hands.

Observation, on 08/13/15 at 9:10 AM, during the morning medication pass on the 100 Unit, revealed the paper towel dispenser in Resident Room 127 was empty, and the licensed nurse obtained facial tissues from the resident in Bed-2 for drying her hands after washing them at the

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room's sink.

Observation, on 08/14/15 at 9:35 AM, on the 100 Unit, revealed the paper towel dispensers in Resident Rooms 105 and 106 were empty.

2. Observation on the 200 Unit, on 08/14/15 at 10:00 AM, revealed the paper towel dispenser was empty in Resident Room 209, and Unit Manager for the 200 Unit had to obtain a package of paper towels to fill the dispenser prior to the licensed nurse (LPN #4) beginning the wound care/dressing change for Resident #4.

Interview, on 08/14/15 at 9:40 AM, with Housekeeper #11 revealed he normally performed housekeeping duties on the 100 Hallway of the facility, and that it was his responsibility to ensure paper towels were available for use in each of the resident's rooms. Housekeeper #11 stated he normally began the daily cleaning of the resident's rooms about 9:30 AM after the breakfast trays had been picked up. Housekeeper #11 stated when he cleaned each resident room sink, he would make sure the paper towel dispensers were refilled, if needed. Housekeeper #11 stated he returned to the unit later in his shift (usually after lunch) to re-clean the bathrooms as needed, and refill the paper towel dispensers.

3. Observation of the 100 Unit, on 08/13/15 at 8:25 AM, revealed twelve (12) rooms from 127-140 had door frames with paint chipped off. The door frames were painted brownish in color, but with the paint chips, the color underneath was white. Room 134 had the most paint chipped off. At least half of the door frame on each side was

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F 253	Continued From page 7 chipped off. 4. Observation of the 200 Unit, on 08/13/15 at 8:45 AM, revealed the fire door had an area of wood chipped off causing jagged edges and splintering, just above the lower third hinge. Interview, on 08/13/15 at 2:32 PM, with the Housekeeping Supervisor, revealed he did audits weekly of privacy curtains, and dispensers, but had no documentation of those audits. He stated the soap dispensers on the 300 Unit lasted a lot longer than the others and the housekeepers must have just missed it. In regards to the empty paper towel dispensers, he stated the 100 Unit had the smaller dispensers so they run out faster. He stated he had on order for the new ones, but was waiting on the approval. Interview, on 08/13/15 at 2:32 PM, with the Maintenance Director revealed he had a contract person who came in about twenty (20) hours a month to do painting. He stated he went hallway by hallway and he just had not got back to the 100 unit yet. He stated it may seem like a lot of time to paint but is wasn't. The Administrator at this time stated she would get approval for ten (10) hours a week for painting.	F 253		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced	F 276		

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by:
Based on interview, record review, and review of the Resident Assessment Instrument Manual, it was determined the facility failed to complete a Quarterly Minimum Data Set (MDS) Assessment within ninety-two (92) days of the Assessment Reference Date (ARD) of the most recent clinical assessment for one (1) of twenty-six (26) sampled residents, (Resident #15).

The findings include:

Review of the Resident Assessment Instrument Users Manual Version 3.0, Chapter 2-30, revealed the quarterly assessment was an Omnibus Budget Reconciliation Act (OBRA) non-comprehensive assessment for a resident that must be completed at least every ninety-two (92) days following the previous OBRA assessment of any type. It's used to track a residents status between comprehensive assessments to ensure critical indicators of gradual change in a residents status is monitored.

Review of the medical record for Resident #15, revealed the facility admitted the resident on 12/31/14 with diagnoses including, Right Below the Knee Amputation, Diabetes Mellitis, Hypertension, and End Stage Renal Disease, Dialysis Dependent. The facility completed an admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date of 01/07/15. The facility did not complete the quarterly assessment until 05/20/15; however, it should have been completed no later than 04/03/15.

Interview, on 08/14/15 at 12:35 PM, with Minimum Data Set (MDS) Registered Nurse, (RN) Coordinator #1, revealed she had been

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F 276	Continued From page 9 doing MDS Assessments for the facility since 2013. She stated the previous coordinator who managed the 300 Unit had recently resigned and there was a new staff person being trained. She stated she could not give an explanation of why the Assessment was late for Resident #15. Interview, on 08/14/15 at 4:30 PM, with the Assistant Director of Nursing revealed she was not very familiar with the MDS process. She stated the purpose of the assessment was to ensure residents were assessed as required and a care plan was developed to identify care needs of the resident. She stated the Director of Nursing was responsible to oversee the assessments and care plan process to ensure work was completed in a timely manor.	F 276		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of facility policy, it was determined the facility failed to ensure residents were invited and attended their care plan meeting and/or care plans were reviewed and revised for four (4) of twenty-six (26) sampled residents. The facility failed to ensure Residents #5, #6, #7, and #15 were invited to their care plan meetings. In addition, the facility failed to revise the care plan and Certified Nursing Assistant (CNA) care card related to Prevalon boots for Resident #6.

The findings include:

The facility did not provide a policy and procedure for care plan revision or care plan meeting notifications.

Review of the facility policy regarding Medical Record Documentation 02/26/15, revealed the resident/legal representative will be notified prior to each interdisciplinary care plan meeting, encouraged to attend, and solicit their input. Name of participants and their responses will be recorded.

1. Review of the medical record for Resident #15, revealed the facility admitted the resident on 12/31/14 with Diagnoses including Right Below the Knee Amputation, Diabetes Mellitus, Hypertension, and End Stage Renal Disease

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(ESRD), Dialysis Dependent. Review of the Admission Minimum Data Set (MDS) Assessment, dated 01/07/15, revealed the facility assessed the residents cognition using the Basic Interview for Mental Status (BIMS) with a score fifteen (15) which meant the resident was cognitively intact and interviewable. Review of the most recent Quarterly MDS Assessment, dated 07/16/15, revealed the facility assessed the resident's cognition with a BIMS score of fifteen (15) meaning cognitively intact and interviewable.

Review of the Comprehensive Care Plan for Resident #15, revealed the facility developed a care plan on 06/11/15 related to impaired communication secondary to short term memory impairment as indicated by the resident repeatedly asking the same questions despite answers given.

Review of the Resident Care Conference Signature Sheet for Resident #15, revealed the facility documented one (1) care conference meeting dated Friday, 05/26/15. The facility indicated the resident and family were invited but did not attend.

Interview, on 08/11/15 at 5:05 PM, with Resident #15 revealed the the facility admitted the resident in January 2015. The resident stated he/she was upset because he/she came to the facility for rehabilitation; however, the resident only received therapy in January and February. The resident stated at the beginning of March they just stopped coming. The resident stated nobody told him/her why, but they told him/her they would schedule a care plan meeting to discuss the situation, but that never happened. The resident stated he/she did not get anymore therapy until

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June 2015, after the left leg was amputated. The resident stated they had not attended a care conference since admission and it was very frustrating because he/she did not know what was going on. He/She stated everyone was telling him/her a different story about why therapy was discontinued. The resident stated he/she went to Dialysis on Mondays, Wednesdays, and Fridays, and had even changed his/her pickup time for dialysis to attend therapy sessions.

2. Review of the medical record for Resident #5, revealed the facility admitted the resident on 07/09/15 with Diagnoses including Urinary Tract Infection, Constipation, History of Cerebral Vascular Accident (CVA) with Hemiplegia, Deformed Right foot and Pressure Ulcer. Review of the Admission MDS Assessment dated 07/26/15, revealed the facility assessed the resident cognition with a BIMS score of fourteen (14), cognitively intact. There was no Care Conference Signature sheet for Resident #5.

Interview, on 08/12/15 at 10:05 AM, with Resident #5 revealed he/she had not been invited to a care plan meeting and did not know if there had been a meeting regarding his/her care and medical treatment.

Interview, on 08/13/15 at 11:10 AM, with MDS Nurse #2 revealed she was still in training and had been doing MDS since March 2015. She stated she was tentatively responsible for the 200 and 300 units assessments and care plans. She stated the previous MDS nurse, who resigned, had made the care plan meeting calender until June 2015. She stated the process for care plan meetings were to schedule the meeting, and send an invitation letter to the resident's contact

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person. She stated the meeting then took place in the office or conference room if family attended and afterwards some of the staff would visit the resident in their room. She stated the residents were not notified or invited prior to the meeting. In addition, she stated residents on the rehab units, (300 unit) had a seventy-two (72) hour meeting. This meeting was held within three (3) days of admission and was considered a care plan meeting. She stated the Discharge Planner, Dietician, Rehabilitation Manager, and Social Services staff attended the meeting. She stated MDS nurses did not attend the seventy-two hour meeting. She stated there was no sign in sheet for this meeting.

Interview, on 08/14/15 at 12:35 PM, with MDS Nurse #1 revealed she was now the MDS Coordinator. She stated she had been trained by the former director about care conferences. She stated residents on the rehabilitation units (300, and 400), were "managed" differently than long term care residents. She stated Licensed Practical Nurse (LPN) #8, who was the discharge planner on the 300 unit, utilized a computer program that developed Care Management Strategies. She stated this was the information presented in the seventy-two (72) hour meeting. This program included an Initial Care Management Meeting note. She stated this information was not based on the Admission MDS Assessment, and the MDS nurses did not attend this meeting. She stated once the resident approached ninety (90) days, the Quarterly MDS was completed and care plan was revised. She stated they sent letters out a month in advance to family members but did not know the resident was to be notified in advance of the care plan meeting. She stated she had no idea about the

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situation with Resident #15.

Interview, on 08/14/15 at 1:35 PM, with LPN # 8 revealed the seventy-two (72) hour meeting was a meeting set up with Therapy, Dietician, Social Services, Nurses and the Discharge Planner to discuss goals and future plan and how long the anticipated stay was for residents. She stated this had nothing to do with the regulatory requirements for MDS assessments and care plan.

3. Review of the clinical record for Resident #7 revealed he/she was admitted to the facility 10/10/14 with diagnoses of General Muscle Weakness, Congestive Heart Failure, Anemia, Bi-Polar Disorder, Depression, Unspecified Essential Hypertension, Chronic Airway Obstruction, Esophageal Reflux Disease, Chronic Kidney Disease, and Insomnia.

Review of Resident #7's most recent Quarterly MDS Assessment, dated 07/07/15, revealed the resident scored 15 (the highest possible rating) on the Basic Interview for Mental Status (BIMS). The facility initiated a care plan for the resident on 10/14/14 with revisions on 11/10/14, 12/16/14, 05/18/15, 05/29/15, 06/12/15, and 08/11/15.

Interview, on 08/11/15 at 3:00 PM, with Resident #7 revealed since the resident's admission to the facility, he/she had not received a verbal or written invitation to his/her care plan meetings.

Review, of the Resident Care Conference Signature Sheet for Resident #7, revealed a resident care conference was held on 04/28/15 the last meeting, but there was no verification provided by the facility that an invitation was

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issued to the resident prior to the meeting.

Interview, on 08/14/15 at 4:30 PM, with the Assistant Director of Nursing revealed she nor the Director of Nursing attended resident care plan meetings. She stated the residents should be invited to their care plan meetings. She stated it was important they attend so they could have input and make recommendations. Also, if there was something they didn't agree with they could tell someone in the meeting. She stated she had not received any complaint from residents regarding not attending or being invited to care plan meetings.

4. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 07/22/15 with diagnoses of Cerebrovascular Disease, Encephalopathy and Pressure.

Review of Resident #6's Admission Minimum Data Set (MDS) Assessment, dated 07/22/15, revealed Resident #6 had a BIMS score of ninety-nine (99) which meant the resident was not interviewable. Resident #6 was triggered for one (1) pressure sore at a Stage II.

Review of Resident #6's Physician Orders, dated 07/24/15 at 10:33 AM, revealed an order for a Prevalon boot to left heel at all times every shift. Review of Resident #6's Physician Orders, dated 07/24/15 at 2:49 PM, revealed an order for a Prevalon boot to right heel at all times every shift.

Observation of Resident #6, on 08/11/15 at 2:30 PM, revealed Resident #6 sitting up in wheelchair with blue non skid socks on. Prevalon boots were located on Resident #6's bed and not applies to the resident.

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Observation of Resident #6, on 08/12/15 at 11:04 AM, revealed the Resident sitting up in his/her wheelchair. Prevalon boots were not applied to Resident #6's feet resting on a foot board.

Review of Resident #6's Comprehensive Care Plan with a focus on pressure, initiated 07/24/15, revealed the care plan was not revised with addition of the Prevalon boots to be placed on both of the resident's feet at all times.

Review of Resident #6's Certified Nursing Assistant (CNA) Care Card, no date provided, revealed the care card was not revised with the addition of the Prevalon boots to be placed on both of the residents feet at all times.

Interview with CNA #9, on 08/13/15 at 10:45 AM, revealed the CNA Care Card had no information relating to the Prevalon boots needing to be on at all times. CNA #9 stated the nurse told her Resident #6 was to have the Prevalon boots on only while in bed.

Interview with the Unit Manager of the Rehab Unit, on 08/13/15 at 10:36 AM, revealed Resident #6 was suppose to have his/her boots on at all times. The Unit Manager stated she updated the CNA Care Cards and reviewed the CNA Care Cards daily. The Unit Manager stated the Comprehensive Care Plans were updated by the nurses on the unit and the Minimum Data Set (MDS) Coordinator. The Unit Manager stated when the nurses obtained new orders they were suppose to update the Comprehensive Care Plan. There was also a morning meeting in which the team updated the Comprehensive Care Plans as well. The Unit Manager stated the Prevalon

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F 280	Continued From page 17 boots were ordered to prevent the wound from getting worse. The Care Plans should have been updated. Interview with the Assistant Director of Nursing (DON), on 08/14/15 at 4:30 PM, revealed the Unit Managers updated the CNA Care Cards. The MDS Coordinator updated the Nursing Care Plans during the clinical meeting. The ADON stated if Resident #6 did not have his/her boots on the wound could become worse.	F 280		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to have an effective system in place to ensure the staff utilized preadmission information to ensure assessment and planning to meet the special needs of one (1) of twenty-six (26) sampled residents, (Resident #26) upon admission to the facility. The facility admitted Resident #26 with diagnoses of Spinal Bifida and Hydrocephalus with a shunt. The facility failed to have a plan was in place to monitor the shunt, and monitor for signs or symptoms of injury after the resident sustained a fall in the van during transport to the facility. On 07/17/15, Resident #26 sustained a subdural hematoma during a facility transfer from another nursing home. The transporting staff failed to	F 281		

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ensure the resident was secured in the van to prevent the resident's scooter from tipping over during a cornering maneuver. After arrival to the facility there was no plan in place to direct the staff in how to monitor the shunt, or monitor for signs or symptoms of potential injury. Interviews with staff revealed the Licensed Practical Nurses should have known about the incident and the shunt to be able to monitor and the MDS Coordinator should have known about the shunt to produce an effective interim care plan for the staff.

The facility's failure to have an effective system in place to ensure staff was provided a plan of care to direct the care of a resident upon admission with special needs has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy and Substandard Quality of Care was identified on 08/21/15 and determined to exist on 07/17/15.

An acceptable Allegation of Compliance (AOC) was received on 08/28/15, alleging the removal of Immediate Jeopardy on 08/27/15. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 08/27/15 as alleged prior to exit on 08/29/15, which lowered the Scope and Severity to a "D" at 42 CFR 483.20 Resident Assessment (F281) while the facility develops and implements the Plan of Correction (POC), and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.

The findings include:

Interview with the Minimum Data Set (MDS) Coordinator, on 08/21/15 at 1:47 PM, revealed

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the facility did not have a policy on communicating preadmission information with staff prior to admission. She stated the facility followed the Resident Assessment Instrument (RAI) MDS 3.0 for the care planning process.

Review of the RAI MDS Manual, Chapter 4, page 4-7, revealed each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Services provided or arranged by the nursing home must also meet professional standards of quality. Therefore, the facility was responsible for assessing and addressing all care issues that were relevant to individual residents, regardless of whether or not they were covered by the RAI, including monitoring each resident's condition and responding with appropriate interventions. However, the process of completing the MDS and related portions of the RAI did not constitute the entire assessment that may be needed to address issues and manage the care of individual residents.

Review of Resident #26's record, revealed the facility admitted the resident on 07/17/15 with diagnoses of Spinal Bifida, and Hydrocephalus with a shunt.

Interview with the Director of Admission, on 08/21/15 at 12:40 PM, revealed normally if a resident was being transferred from a nursing home, the nursing home would call with the referral, she gathered all of the clinical observations from the chart, history and physical, face sheet, discharge summary, medication sheets, therapy sheets, nursing notes and Social Services notes. Then fax the information to the

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Assistant Director of Nursing (ADON) or Director of Nursing (DON) to review clinical information to see if the facility could meet the needs of the resident.

Further interview with the Director of Admission on 08/21/15 at 12:40 PM, revealed the facility normally did not transport residents. The discharging facility would normally provide the transportation. However, the Director of Admission stated Resident #26's admission was not a routine nursing home transfer. She stated the process was rushed, trying to get the residents out of the other facility during a specific time frame, and she was not involved in that transportation process.

Interview with the Administrator, on 08/21/15 at 4:37 PM, revealed she was the one who completed an assessment of Resident #26 upon admission to the facility. The Administrator stated Resident #26 was not one of the original residents to be transferred to her facility. Resident #26 wanted to go with a friend (Unsampled Resident G). Resident #26's preadmission assessment was completed on Thursday, 07/16/15. The Administrator stated it was not much of an assessment because the previous facility was trying to get residents out as soon as possible. The Administrator stated Resident #26 was alert and oriented x 3 (person, place and time) and so high functioning she had to ask what was wrong with the resident. The Administrator asked Resident #26 was he/she totally independent and Resident #26 stated he/she could transfer him/herself from scooter to bed and bed to scooter.

Review of Resident #26's nursing notes,

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completed by the DON, on 07/17/15 at 1:30 PM, revealed Resident #26 was transferred to the facility on a bus when Resident #26's wheelchair tilted over en route. Resident #26 stated he/she did not hit his/her head. Resident #26 did complain of a migraine headache that he/she had prior to leaving the discharging facility. No other apparent injury was noted. Continued review of the clinical record revealed there was no interim care plan developed for Resident #26 related to the monitoring of the resident's shunt or the fall sustained during transport.

Interview with the Administrator, on 08/21/15 at 4:37 PM, revealed she did not have a plan of care for Resident #26 until the resident arrived to the facility. There was a twenty-four (24) hour period to complete an assessment. The Administrator stated she informed the Unit Manager on the 100 hall to watch the resident closely after the fall.

Interview with the Unit Manager of the 100 hall, on 08/21/15 at 1:11 PM, revealed Resident #26 came to the facility around lunch time and asked about pain medication for a complaint of a headache, which he/she had all day. The Unit Manager stated the Administrator and ADON, informed her that Resident #26 had fallen out of his/her scooter while in transport to the facility. The Unit Manager stated Resident #26's nurse started the neurological checks, which was the facility's protocol when a fall was un-witnessed. The Unit Manager further stated she asked the Advanced Practical Registered Nurse (APRN) if she could have an order for the neurological checks, but he never gave a yes or no answer. However, review of the clinical record revealed there were no neuro-checks documented as completed by nursing staff.

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Interview with the Advanced Practice Registered Nurse (APRN), on 08/14/15 at 12:50 PM, revealed he completed a neuro check on Resident #26 and the neuro check was not alarming. Resident #26 gave appropriate responses. The APRN stated it was the facility's practice to do neuro-checks on un-witnessed falls. He believed the ADON informed him Resident #26 fell on their bottom and that the fall was witnessed. The APRN stated if the fall was unwitnessed he would have encouraged the nurses to complete neuro-checks because of the shunt.

Further interview with the Unit Manager of the 100 hall, on 08/21/15 at 1:11 PM and 3:30 PM, revealed the ADON did not inform her of the need for special care with Resident #26 and she was not afforded the opportunity to get a report from the prior facility in regards to the history of Resident #26. The Unit Manager stated she would have wanted to know Resident #26 had Spinal Bifida and Hydrocephalus with a shunt. She stated when a resident developed a Hematoma things could change rapidly. The Unit Manager stated she did not initiate a care plan upon admission. There should have been a plan to monitor Resident #26's vitals and over all status.

Continued interview with the Unit Manager of the 100 hall, on 08/21/15 at 3:30 PM, revealed LPN #9 knew what had happened to Resident #26 and was responsible to report to the oncoming nurse. The Unit Manager stated she informed LPN #9 to make sure she monitored Resident #26 and that Resident #26 had chronic headaches.

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Interview with the Licensed Practical Nurse (LPN) #9, on 08/14/15 at 2:15 PM, revealed the Unit Manager completed Resident #26's admission. LPN #9 stated she took some vitals for the Unit Manager and placed some medications into the computer system. She remembered giving report to the oncoming nurse about a fall with a transfer and the fact that Resident #26 hit his/her head. LPN #9 stated she completed a pain assessment and administered Baclofen for muscle spasms, but no neuro-checks were completed.

Interview with Registered Nurse (RN) #5, on 08/14/15 at 9:40 AM, revealed she took report from LPN #9 and did not recall any information about Resident #26 having a fall. She stated she did not receive a good report and noticed in Resident #26's chart that he/she had a history of migraines, shunt with Hydrocephalus and Spinal Bifida. RN #5 stated Resident #26 was able to verbalize that he/she had sustained a fall in the facility van but did not hit his/her head. Per interview, if the resident did hit their head, they were to get another nurse and assess the resident. RN #5 stated if a fall was not witnessed the nursing staff must assume that the resident could have hit their head, and neuro-checks were to be initiated. RN #5 stated LPN #9 did not report to her that Resident #26 was to have neuro-checks. RN #5 stated when they provided neuro-checks to residents she assessed the resident's pupils for reaction to light and if there was any weakness.

Review of Resident #26's record, revealed only one (1) neuro check was provided by the APRN on 07/17/15 with no time provided. No other neuro-checks were documented.

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Continued interview with RN #5 on 08/14/15 at 9:40 AM, revealed Resident #26 verbalized he/she needed to go to the hospital. RN #5 obtained Resident #26's blood pressure as 178/116 and the resident was transferred to the hospital at 4:29 PM.

Review of the twenty-four (24) hour report, dated 07/17/14, revealed Resident #26 was admitted from another facility on the 7-3 shift and sent out to the hospital on the 3-11 shift. There was no documentation of a fall or special instructions for monitoring Resident #26's shunt.

Interview with the MDS Coordinator, on 08/21/15 at 1:47 PM, revealed it should have been known Resident #26 was coming with a plan in place for him/her. She stated she would have developed a plan such as monitoring Resident #26's shunt for signs and symptoms of infection, fluid on the brain, swelling, taking vitals and monitoring for headaches. There would also be a neurological care plan because it had to do with the brain. The MDS Coordinator stated had she known the resident's history of a shunt and the fall she would have had the opportunity to develop a care plan that was more individualized. However, she did not know about the fall until after the resident went to the hospital.

Review of Resident #26's Emergency Room visit, on 07/17/15 at 5:32 PM, revealed Resident #26 presented with a sharp, throbbing headache and a pain level of nine (9) out of ten (10) (one (1) no pain to ten (10) being the worst pain). The resident stated that he/she was on his/her mobility scooter in the van when his/her husband went around a corner, causing his/her scooter to tip over. Resident #26 stated that he/she struck

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his/her head. The resident also complained of pain radiating down the neck, nausea and vomiting six (6) times, photophobia (abnormal intolerance to visual perception of light), phonophobia (fear of loud sounds). Resident #26 developed a left hemispheric subdural hematoma measuring up to one (1) centimeter (cm) in maximal thickness.

Interview via telephone with the Medical Doctor, who completed the hospital Discharge Summary, on 08/21/15 at 9:09 AM, revealed Resident #26 sustained a Post Traumatic Subdural Hematoma which played a role in Resident #26's decline. The pain radiating down his/her neck and complaints of nausea and vomiting were contributed by his/her fall and the hematoma he/she sustained. The cause of Resident #26's death was related to the hematoma. The Medical Doctor stated Resident #26 sustained an Acute Hematoma which meant it occurred the day of admission.

Review of the Discharge Summary from the hospital, revealed Resident #26 expired, on 08/01/15 at 3:00 PM, related to complications from the subdural hematoma.

The facility alleged the removal of Immediate Jeopardy by implementing the following:

1. On 07/17/15 Resident #26 was assessed by the Assistant Director of Nursing at approximately 12:15 PM for any injuries/pain at the time of incident.

2. On 07/17/15 at 12:40 PM, the Advanced Registered Nurse Practitioner assessed Resident #26 for signs of trauma.

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3. On 07/17/15, the Assistant Director of Nursing notified the Executive Director of the fall Resident #26 had sustained and that an investigation into the incident had started.

4. On 07/17/15, the Executive Director interviewed the Maintenance Director, the Assistant Director of Nursing and another resident riding on the bus.

5. On 07/17/15 at 12:45 PM, the Licensed Practical Charge Nurse conducted an assessment of Resident #26.

6. The Registered Charge Nurse notified the Advanced Registered Nurse Practitioner of Resident #26's change in condition, at 4:00 PM on 07/17/15, and received an order to transfer the resident to the hospital for an evaluation.

7. The Assistant Director of Nursing reviewed reports of falls that occurred within the first twenty-four hours of admission. The Assistant Director of Nursing's review of the reports determined four residents had sustained falls within twenty-four hours of admission.

8. The four resident's identified, that fell within twenty-four hours of admission, had their medical record reviewed by the Assistant Director of Nursing for timeliness of assessment and for the immediate development of the plan of care to meet the needs of the residents. The Assistant Director of Nursing determined the four resident's medical records contained a timely assessment and a plan of care.

9. The Director of Nursing and the Assistant

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Director of Nursing initiated an in-service education on, 08/21/15 and 08/25/15, for all full and part-time licensed nursing staff; 49 in total were trained. The training included: conducting resident admission assessments, creating the Immediate Plan of Care, updating care plans and Certified Nursing Assistant assignment sheets. In addition, the in-service covered timely completion of incident reports and documentation of changes in a resident's condition via the Situation, Background, Assessment, and Response (SBAR) model for documenting, and Physician and Family Notifications. The facility noted no other nurses would be allowed to work without first receiving this training.

10. The Clinical Liaisons (CL), which included Registered Nurses or Licensed Practical Nurses, would review potential resident admissions' for special needs, interventions, or equipment. From the review the facility would plan the resident's admission to ensure the identified needs, interventions or equipment would be in place at the time of admission, which included communicating the resident's needs to the Unit Managers.

11. The Unit Managers would ensure that the interventions, special needs or equipment were in place on admission, the care plan would reflect this information, and staff would be trained on resident care needs.

12. New resident admissions were reviewed in clinical morning meeting by the Unit Managers to ensure assessment, plan of care and documentation had been completed timely and accurately.

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13. The facility policies titled: Accident Investigation, dated 06/17/15; Accident Investigation, Cause(s) of Accidents, dated 07/07/15; Interdisciplinary Care Plan, dated 02/26/15, and Resident Transport Policy, dated 08/01/11, were reviewed by the Executive Director, the Assistant Director of Nursing, and the Activities Director on 08/23/15 and it was determined no policy changes were needed.

14. After Resident #26's fall and before continuing to drive to the facility, the Maintenance Director verified the seatbelts and wheelchair restraint systems were in place for two (2) additional residents on the van with Resident #26.

15. The Maintenance Director and all facility personnel authorized to transport residents in the facility's van received training on the facility van's wheelchair lock-down system and on the Resident Transport Policy on 07/28/15. The training was provided by the facility's Activities Director.

16. Facility personnel authorized to transport residents would be retrained quarterly for four (4) quarters and annually, thereafter.

17. Safe resident transport would be based on the residents' individual needs. The Activities Director would review a resident's assessments and have discussion with the resident's charge nurse regarding the best ways to safely transport the resident.

18. The Human Resources Generalist and the Executive Director reviewed the files of personnel authorized to transport residents in the facility's van to ensure training and competencies were

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completed. In addition, these employees' files would be audited quarterly for four (4) quarters and then annually.

19. The Quality Assurance Performance Improvement Committee met on 08/23/15 with the following staff persons in attendance: Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Social Worker, Unit Managers, Director of Resident Assessment, Human Resources Generalist, Maintenance Director, Corporate Director of Clinical Education, and the Medical Director to review assessments and monitoring tools.

The State Survey Agency validated the removal of Immediate Jeopardy on 08/29/15 as follows:

1. Interview, on 09/02/15 at 2:20 PM with the Assistant Director of Nursing, revealed Resident #26 was assessed immediately at the time of his/her fall in the van.

2. Review of the Advanced Registered Nurse Practitioner's documented assessment, dated 07/17/15, revealed Resident #26 was assessed by the ARNP.

3. Interview with the Executive Director, on 09/02/15 at 2:00 PM, revealed the Executive Director was notified of the incident on 07/17/15 by the Assistant Director of Nursing. Review of the Verification of Investigation, revealed investigation of the incident was initiated on 07/17/15.

4. Interview with the Executive Director, on 09/02/15 at 2:00 PM, revealed on 07/17/15 the Executive Director interviewed the Maintenance

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Director, Assistant Director of Nursing and another resident who had been on the bus, as she initiated an investigation of the incident.

5. Review of the admission assessment titled Clinical Health Status, dated 07/17/15, revealed an assessment of Resident #26 was conducted.

6. Review of the Medication Administration Record and the Clinical Nursing Note for Resident #26, dated 07/17/15, timed 3:30 PM, revealed the resident received Promethazine 12.5 milligrams for nausea and vomiting. Further review of the clinical nursing note revealed the Registered Nurse in charge notified the Advanced Registered Nurse Practitioner of Resident #26's change in condition, at 4:00 PM on 07/17/15, and received an order to transfer the resident to the hospital for an evaluation.

7. Review of an aggregate list of resident falls, titled Total Events by Type, dated 02/22/15 to 08/22/15, revealed the facility's Assistant Director of Nursing identified four (4) residents, in addition to Resident #26, who had fallen within twenty-four (24) hours of their admission to the facility.

8. Interview, on 08/29/15 at 3:42 PM with the Assistant Director of Nursing, revealed upon review of the records of the four (4) residents who fell within 24-hours of admission, all were non-injury falls and none of the four (4) residents required transfer to the hospital for evaluation. The Assistant Director of Nursing stated she reviewed the time of day each resident was admitted to the facility and their diagnoses. The Assistant Director of Nursing stated she also reviewed the residents' physician orders/prescribed medications, and admission

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assessments.

Interview, on 08/29/15 at 2:50 PM with the MDS Coordinator revealed she reviewed care plans of the four (4) residents identified with falls within twenty-four (24) hours of admission, and determined the residents' care plans did not need to be updated.

9. Review of the document titled, Summary Report of Meeting: Nursing Lecture, Dated 08/21/15, revealed the facility's Director of Nursing and Assistant Director of Nursing initiated in-service education on 08/21/15 for the licensed nursing staff on resident admission assessments, creating the Immediate Plan of Care (IPOC), updating care plans and updating Certified Nursing Assistant assignment sheets. In addition, the in-service covered timely completion of incident reports and documentation of changes in a resident's condition using the Situation Background Assessment Response (SBAR) model for documentation, and on Physician/Family notifications.

Review of the document titled, Summary Report of Meeting: Nursing Lecture, dated 08/21/15, revealed the training was provided to forty-nine (49) licensed nurses and had signed they received the training.

Interview, on 08/29/15 at 1:20 PM with the Executive Director, revealed there were 49 nurses employed by the facility who were currently authorized to work on the nursing units, and all had completed the required training.

Interview on 08/29/15 at 3:05 PM with the Corporate Director of Clinical Services revealed

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the facility's Director of Nursing and Assistant Director of Nursing had been trained on conducting Resident Admission Assessments, creating the IPOC, updating care plans and Certified Nursing Assistant assignment sheets. The Corporate Director of Clinical Services stated this training also included documentation using the SBAR method when there was a change in a resident's condition, and completion of incident reports.

Review, of the sign-in sheet for the training provided by the Corporate Director of Clinical Services revealed facility's Director of Nursing and Assistant Director of Nursing signed that they attended the training.

Interview, on 08/29/15 at 3:42 PM with the Assistant Director of Nursing, revealed newly hired licensed nurses would receive training on completing admission assessments, creating the IPOC, updating the Certified Nursing Assistant care assignments, documenting via the SBAR when there was a change in a resident's condition, and completing incident reports. Nurses would not work on the nursing units until they had completed the training.

Interview, on 08/29/15 at 2:32 PM with Licensed Practical Nurse #14, revealed she received training within the past week on admission assessments, completing incident reports and documenting using the SBAR method when there was a change in a resident's condition. Licensed Practical Nurse #14 stated, when she admitted a resident, her responsibilities included obtaining necessary authorizations from the resident or his/her legal representative, conducting a resident assessment, and initiating the resident's IPOC.

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Interview, on 08/29/15 at 1:15 PM with the 400 Hallway Unit Manager (UM), revealed she received in-service education in the past week on admission assessments, completing incident reports and documenting using the SBAR method when there was a change in a resident's condition. The 400 Unit Manager stated when a resident was admitted to the 400 Hallway, she reviewed all admission paperwork received from other facilities and reviewed and in-put the orders obtained from the resident's physician. The 400 Hallway Unit Manager stated if not on duty at the time of an admission, she reviewed the resident's paper work and orders, and personally visited the resident upon her return to work.

Interview, on 08/29/15 at 3:13 PM with the 200 Unit Manager, revealed she received recent in-service education on conducting admission assessments, completing SBARs and incident reports. In addition, the 200 Hallway Unit Manager stated the 24-hour shift report was the mechanism used for recording and communicating information about a resident's status, any new care areas, and any changes in a resident's condition over the 24-hour period. The 200 Hallway Unit Manager stated she reviewed the 200 Hallway 24-hour report every morning to ensure continuity of reporting of the residents' status across all shifts.

Interview, on 08/29/15 at 2:50 PM with the MDS Coordinator revealed she received recent in-service education on care planning for newly admitted residents, and on how nurses were to complete the initial admission assessment packet. The Director of Resident Assessment stated she was also trained on completing

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incident reports and documenting using the SBAR method in clinical notes. The Director of Resident Assessment/Minimum Data Set Nurse stated if a resident experienced a change in condition, such as a fall, a licensed nurse should assess the resident, put immediate interventions in place to protect and/or treat the resident's injury, if any. The care plan should be updated and the documentation should also include the SBAR and a completed incident report. The Director of Resident Assessment/Minimum Data Set Nurse stated the incident report(s) were later reviewed by the Quality Assurance Committee.

10. Interview, on 08/29/15 at 4:30 PM with the facility's Executive Director, revealed the corporation's clinical liaisons conducted pre-admission assessments for potential residents. The Executive Director stated the clinical liaisons forwarded the assessments to her, and along with the Director of Nursing and/or Assistant Director of Nursing, and the Admissions Director, she reviewed the data to determine the level care the potential resident would require, and any special equipment or arrangements the facility would need to secure prior to the resident's admission.

11. Interview, on 08/29/15 at 1:15 PM with the 400 Unit Manager, revealed when a resident was admitted to the 400 Hallway, she reviewed all admission paperwork received from other facilities and reviewed and in-put the orders obtained from the resident's physician. She stated the residents' clinical records were reviewed ensure the care plan was initiated, and that the Certified Nursing Assistant Care Record assignments, and the care interventions were communicated to the staff. The 400 Hallway Unit

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Manager stated if not on duty at the time of an admission, she reviewed the resident's paper work and orders, and personally visited the resident upon her return to work.

12. Review, on 08/29/15 of the Resident Admission Monitoring Tool, revealed the facility had admitted eight (8) residents since 08/26/15. The residents' clinical records were reviewed by the facility's Unit Managers, who signed/dated when they reviewed the residents' records for plan of care, Certified Nursing Assistant Care Record assignments, and for implementation of the care interventions, as planned. According to the Unit Manager's signatures with dates, all eight (8) records had been reviewed for the required components within one (1) day of each resident's admission to the facility.

Interview, on 08/29/15 at 3:42 PM, with the Assistant Director of Nursing revealed she would be responsible for ensuring all components of the admission documentation was completed for newly admitted residents. The Assistant Director of Nursing stated the Unit Managers and the Minimum Data Set Nurses were also responsible for ensuring all necessary admission documentation was completed. In addition, the Assistant Director of Nursing stated she would review the new admission audits conducted by the Unit Managers, and these documents would be discussed daily in clinical morning meetings. The Assistant Director of Nursing stated, to date, no corrective action had not been necessary as the admission documentation has been completed for new admissions as required.

13. Interview, on 08/29/15 at 1:20 PM with the Executive Director, revealed she and the

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Assistant Director of Nursing reviewed following policies 08/23/15: Accident Investigation, dated 06/17/15; Accident Investigation, Cause (s) of Accidents, dated 07/07/15; and Interdisciplinary Care Plan, dated 02/26/15, no changes to the policies were made.

Interview, on 09/02/15 at 2:35 PM, with the Activities Director revealed she reviewed the Resident Transport Policy with the facility's Executive Director, and recently retrained the staff authorized to drive the facility's van.

14. Interview, on 09/02/15 at 3:20 PM with the facility's Maintenance Director, revealed once the Assistant Director of Nursing assessed Resident #26 after his/her fall on the van, he ensured Resident #26's wheelchair lock-down system and seatbelts were secured and fastened. In addition, the Maintenance Director stated he also observed the other two residents on the van to ensure their wheelchairs/safety belts were secured/fastened before moving the van.

15. Interview, on 09/02/15 at 2:35 PM with the Activities Director, revealed on 07/28/15, she retrained the facility's authorized van drivers on safe resident transport and proper use of the van's wheelchair lock-down system.

16. Review of the document titled, Quarterly Drivers Files Audit, No Date, revealed the drivers' files would be audited for re-training competencies on 10/28/15, 01/28/16, 04/28/16 and 07/28/16.

17. Interview, on 08/29/15 at 2:50 PM with the Director of Resident Assessment/MDS revealed, on 08/28/15, the Activities Director consulted with

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the Director Of Assessment/Minimum Data Set Nurse prior to transporting a resident who had a lap tray affixed to his/her wheelchair. The Director of Resident Assessment/Minimum Data Set Nurse stated she referred the Activities Director to Therapy Department as she thought therapy staff could best answer the question related to the resident's wheel chair tray.

18. Interview, on 08/29/15 at 3:22 PM with the Human Resources Generalist, revealed she reviewed the records for all authorized van drivers to ensure their drivers' licenses and Department of Transportation certifications were in-date, and for verification of re-training on the van's wheelchair restraint system. The Human Resources Generalist stated she was assigned to monitor the van drivers records for the required competencies and for verification of quarterly retraining for one year, and thereafter she would conduct an annual review of their records.

19. Review of the document titled, Ad Hoc QAPI, dated 08/23/15, revealed the Executive Director, the Director of Nursing, the Assistant Director of Nursing, the facility's Social Worker, Unit Managers for four (4) of four (4) nursing units, the Director of Resident Assessment, the Human Resources Generalist, the Maintenance Director, the Corporate Director of Clinical Education, and the facility's Medical Director attended the QAPI meeting.

Interview with the ADON, on 08/29/15 at 3:42 PM, revealed she would oversee the monitoring that would occur by the Unit Managers and MDS Nurses, for the new admission process, complete all proper documentation, all new admissions will be discussed during the daily clinical meetings,

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F 281	Continued From page 38 twenty-four hour reports would be reviewed at the clinical meeting. The ADON stated she would also be attending the QA meetings and providing progress of the monitoring process for admissions and changes of condition. Interview with the Administrator, on 08/29/15 at 4:30 PM, revealed nurses were assigned to monitor tasks described in the AOC to ensure that all residents newly admitted have been assessed and screened by the new process and interventions put in place. The Administrator stated she would have the AOC minder at each morning meeting to review and to check to ensure assigned staff were continuing to monitor for compliance with the plan.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of twenty-six (26) sampled residents care plan interventions were followed. Observations of Resident #3 revealed the staff failed to ensure there were fall mats or wheel chair alarms in the resident's room. The findings include: The facility did not provide a policy related to	F 282		

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following comprehensive care plans.

Review of the clinical record for Resident #3, revealed the resident was admitted to the facility on 02/27/14 with diagnoses of Communicating Hydrocephalus, Diabetes Type II, Disorganized type Schizophrenia, and Acquired Hemolytic Anemia's.

Review of the Annual Minimum Data Set (MDS) Assessment for Resident #3 dated 02/25/15 revealed falls triggered as an area of concern that may warrant interventions on the Care Area Assessment Summary. The Quarterly MDS Assessment, dated 06/08/15, revealed the facility assessed Resident #3 to be totally dependent on staff for his/her Activities of Daily Living and totally dependent on staff for transfers. The resident scored a ten (10) out of fifteen (15) on the Brief Interview for Mental Status (BIMS) meaning the resident was interviewable.

Review of the Falls Incident Reports revealed Resident #3 had non-injurious falls on 03/15/15, when he/she tried to get out of bed unassisted, on 05/11/15, after he/she rolled out of bed, and on 5/15/15, when he/she was trying to get out of bed unassisted.

Review of the Comprehensive Care Plan for Resident #3 initiated on 07/18/14 and last reviewed on 08/11/15 with a target date for 09/28/15, revealed the resident was to have bilateral fall mats and a tab alarm to his/her wheelchair due to a history of falls, and impaired mobility. These interventions were initiated on 11/11/14.

Review of the Certified Nursing Assistant (CNA)

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Care Guide, not dated, revealed Resident #3 was to have an alarm to his/her wheelchair and did not mention the use of fall mats as intervention to prevent falls.

Observations of Resident #3, on 08/11/15 at 1:40 PM, 2:20 PM, 3:05 PM, 5:10 PM, and on 08/12/15 at 12:10 PM, and 1:15 PM, revealed the resident sitting in his/her wheelchair and did not have an alarm on the chair. Observations of Resident #3, on 08/12/15 at 7:45 AM, 09:00 AM, and 10:00 AM, revealed the resident was in bed and there were no fall mats on either side of the resident's bed.

Interview with Resident #3, on 08/12/15 at 1:15 PM, revealed the resident did not remember the last time he/she saw fall mats in his/her room or an alarm on his/her wheelchair.

Interview with CNA #1, on 08/13/15 at 9:45 AM, revealed she looked at the CNA care guide to see what devices a resident needed.
She stated she knew the resident was to have the alarms and fall mats to prevent falls; however, she did not know where Resident #3's wheelchair alarms or fall mats were or when she last saw them.

Interview with Licensed Practical Nurse (LPN) #1, on 08/13/15 at 2:30 PM, revealed the Inter-Disciplinary Team (IDT) goes to the resident's room during care plan meetings to make sure the resident has the equipment they need. The last care plan date was 06/08/15. She verified the fall mats and alarm were not in the resident's room. She stated she did not know where the chair alarm or fall mats were.

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F 282	Continued From page 41 Interview with Minimum Data Set Coordinator, on 08/14/15 at 7:25 AM, revealed fall mats and wheelchair alarms were nursing interventions and were added to care plans after a resident fall. She stated if fall mats and wheelchair alarm were on Resident #3's care plan, then they should be in the resident's room. Attempted interview with the Unit Manager revealed she was on vacation. Interview with the Assistant Director of Nursing, on 08/14/15 at 8:32 AM, revealed the Unit Managers ensured interventions were in place for residents when they do their rounds on the unit. She stated interventions on the care plan should be reflected in the resident's room. She stated fall mats helped prevent injuries from falls and wheelchair alarms alerted staff when a resident attempted to transfer unassisted.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility	F 314		

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failed to ensure one (1) of twenty-six (26) residents, Resident #6 was provided the necessary treatments to promote healing to his/her heel.

The findings include:

Review of the Prevention of Pressure Ulcer Policy and Procedure, effective 01/26/15, revealed the purpose of the procedure was to prevent skin breakdown and the development of pressure sores. The assessment guidelines detailed equipment used for pressure sore prevention included heel protectors. The procedure detail included use of elbow and heel protectors as necessary; and, use of pressure reducing or relieving devices as necessary. Documentation guidelines stated preventive equipment used should be documented. The procedure further stated the care plan should include a list of pressure reducing or relieving surfaces.

Review of the clinical record for Resident #6 revealed the facility admitted the resident on 07/22/15 with diagnoses of Cerebrovascular Disease, Hypothyroidism, Metabolic Encephalopathy, Chronic Heart Failure and Pressure.

Review of Resident #6's Admission Minimum Data Set (MDS) Assessment, dated 07/22/15, revealed the facility assessed Resident #6 with a BIMS score of ninety-nine (99) which meant the resident was not interviewable. Resident #6 was triggered for one (1) pressure sore at a Stage II.

Review of Resident #6's Wound Evaluation Flow Sheet, dated 07/23/15 at 3:19 PM, revealed Resident #6 had pressure to the right heel, length

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4.8, width 3.2 and staged at a Stage II, which meant partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough or an intact or open/ruptured serum-filled blister.

Interview and observation with Registered Nurse (RN) #4, on 08/13/15 at 11:09 AM, revealed Resident #6's left heel was fluid filled, but had hardened.

Review of Resident #6's Physician Orders, dated 07/24/15 at 10:33 AM, revealed an order for a Prevalon boot to left heel at all times every shift. Review of Resident #6's Physician Orders, dated 07/24/15 at 2:49 PM, revealed an order for a Prevalon boot to right heel at all times every shift.

Review of Resident #6's Pressure Sore Care Plan, initiated 07/24/15, revealed the Prevalon boots were not updated to the care plan to be placed on both of the resident's feet at all times. In addition, the CNA Care Card, not dated, revealed the Prevalon boots to be placed on both of the residents feet at all times was not on the care card.

Observation, on 08/11/15 at 2:30 PM, of Resident #6 revealed Resident #6 was sitting up in a wheelchair without the Prevalon boots on instead the resident was wearing blue, non-skid socks. The Prevalon boots were located on Resident #6's bed.

Observation of Resident #6, on 08/12/15 at 11:04 AM, revealed the resident was sitting up in his/her wheelchair. Resident #6 was watching a moving at this time on his/her computer. Resident #6 did

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F 314	Continued From page 44 not have on Prevalon boots at this time, just non-skid socks. Resident #6's feet were resting on a foot board. Interview with Certified Nursing Assistant (CNA) #9, on 08/13/15 at 10:45 AM, revealed the nurse informed her to place Prevalon boots on Resident #6's feet only when in bed. CNA #9 stated she was aware Resident #6 had pressure to his/her feet, but was not aware the Prevalon boots were to be placed on Resident #6's feet at all times. Interview with the Unit Manager of the Rehab Unit, on 08/13/15 at 10:36 AM, revealed the Prevalon boots were suppose to be on Resident #6's heels at all times to offset the pressure to his/her heel. The Unit Manager stated she was trying to prevent the wound from becoming worse. Observation of wound care, on 08/13/15 at 11:09 AM, revealed the wound to the left heal was observed to be hardened and not fluid filled. Interview with the Assistant Director of Nursing, on 08/20/15 at 10:09 AM, revealed assistive devices should be utilized to prevent pressure. The Unit Manager was to monitor the pressures daily and report on them in the morning meetings.	F 314		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and policy review, it was determined the facility failed to have an effective system in place to ensure two (2) of twenty-six (26) sampled residents, Resident #26 and Resident #3 received assistive devices to prevent accidents. The staff failed to ensure Resident #26 was secured in a van for transport resulting in an injury. In addition, the staff failed to ensure Resident #3 was provided the assistive devices as care planned.

On 07/17/15 the facility staff transported Resident #26 in a facility van from another nursing home. The staff failed to secure the resident via all available safety restraints. The resident's three (3) wheel scooter tipped over during transport and the resident fell from the scooter. The resident was subsequently transferred to the Emergency Room on 07/17/15 with a diagnosis of Subdural Hematoma and expired on 08/01/15 from complications. The facility failed to complete a Situation Background Assessment Recommendation (SBAR) form for Resident #26 until the resident was sent to the hospital. The facility also failed to document the fall on the twenty-four hour report; therefore, nursing staff was not all aware of the fall or the details related to the fall the resident sustained.

The facility's failure to have an effective system in place to provide adequate supervision to ensure resident safety during facility transport has caused or is likely to cause serious injury, harm,

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impairment, or death. Immediate Jeopardy was determined to exist on 07/17/15 and the facility was notified on 08/21/15.

An acceptable Allegation of Compliance (AOC) was received on 08/28/15, alleging the removal of Immediate Jeopardy on 08/27/15. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 08/27/15 as alleged prior to exit on 08/29/15, which lowered the Scope and Severity to a "D" at 42 CFR 483.25 Quality of Care (F323) while the facility develops and implements the Plan of Correction (POC), and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.

The findings include:

1. Review of the Falls Management Guidelines, reviewed 06/26/15, revealed following a resident's fall, the licensed nurse assesses the resident for injuries (including neuro checks if indicated) and provides necessary treatment and initiates the Change in Condition Report - Post Fall/Trauma. The physician and resident's representative would be notified and the appropriate interventions would be initiated. The licensed nurse initiated the DQI Quality Control Report. The Interdisciplinary Team reviewed the Change of Condition Report - Post Fall/Trauma and made additional recommendations within 72 hrs of the fall.

Review of the facility's witnessed, unwitnessed fall protocol, dated 08/14/15, revealed any fall that was seen by another person, alert and oriented x three (3) was considered a witnessed fall. This person could be another resident, visitor, staff member, etc. that seen the fall. If they could

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report they saw the fall it would be considered witnessed.

Review of the Neurological (Neuro) Checks Policy, reviewed 12/18/14, revealed it was the policy of the facility to conduct neurological checks on residents clinically appropriate (whenever their was a question of a head injury or a change in neurological status or level of consciousness). Each facility should establish a protocol for the frequency. Neurological checks should be performed per physician order.

Review of the clinical record for Resident #26 revealed the facility admitted the resident on 07/17/15 with diagnoses of Spina Bifida with Hydrocephalus with a shunt, Hypothyroidism and Nausea and Vomiting, Unspecified Essential Hypertension and Chronic Headaches. Physician ordered medications were Plavix (to prevent blood clots) 75 milligrams (mg) daily, Aspirin (treat pain, fever and inflammation) 81 mg daily and Maxolt (migraine headaches) 10 mg as needed for headache.

Interview with the Assistant Director of Nursing (ADON), on 08/13/15 at 10:00 AM and at 5:00 PM, revealed on 07/17/15 between 11:30 AM and 12:00 PM, she and the Maintenance Director went to pick up three (3) residents, Resident #26 and Unsampled Residents F and G, from another facility and utilized the facility's own company van.

Interview with the Maintenance Director, on 08/13/15 at 3:30 PM, revealed he placed Resident #26 onto the van with no help from the ADON. The Maintenance Director stated he placed Resident #26, who was in a three (3) wheel scooter, in the fourth spot behind the

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driver's seat. He attached two (2) belts to the rear two (2) wheels and attached two belts to the front one (1) wheel of Resident #26's scooter. The Maintenance Director was able to adjust for tightness, though he had a difficult time adjusting the belts to the front wheel.

Further interview with the Maintenance Director, on 08/13/15 at 10:30 AM, revealed he did not remember securing Resident #26's seatbelt.

Interview with the ADON, on 08/20/15 at 10:09 AM, revealed she did not double check to make sure Resident #26's seat belt was secured.

Continued interview with the ADON, on 08/13/15 at 10:00 AM, revealed when the van took off they were half way down the street when she heard a noise, and the Maintenance Director, driving the van, stopped the van and noticed Resident #26 was sitting on the floor on his/her bottom. The ADON stated she got up and went to Resident #26 who stated he/she did not hit his/her head, but that it scared him/her. The ADON assessed Resident 26's range of motion. The Maintenance Director and the ADON assisted Resident #26 back into his/her scooter. The ADON then made sure Resident #26 scooter was secured, locked and stayed at Resident #26's side the remainder of the trip. Resident #26 stated nothing hurt him/her just a headache that he/she had all day.

Interview, on 08/13/15 at 04:35 PM, with Unsampled Resident G, whom the facility assessed with a Basic Interview for Mental Status (BIMS) score of fifteen (15) meaning the resident was interviewable, revealed he/she was riding in the new facility's van from the "old facility", on 07/17/15, when he/she heard a "thump" noise

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and he/she turned around and saw Resident #26 still positioned in his/her wheelchair turned over to the right side on the floor. Unsampled Resident G stated that he/she did not witness the incident because he/she was sitting in front of Resident #26. Unsampled Resident G stated the van did not have any type of accident and the driver must have turned a corner when this incident happened. Unsampled Resident G stated that Resident #26 did tell him/her, that he/she hit his/her head during that fall.

Attempted interview with Unsampled Resident F, on 08/13/15 at 4:25 PM, revealed the resident did not remember anything about the incident with Resident #26.

Continued interview with the ADON, on 08/13/15 at 10:00 AM, revealed the Advanced Practical Registered Nurse (APRN) did an assessment of Resident #26 upon arriving to the facility.

Interview with the APRN, on 08/13/15 at 10:11 AM and on 08/14/15 at 12:50 PM, revealed he completed an assessment of Resident #26 and found that Resident #26 had chronic headaches and was on Imitrex for headaches. The APRN stated he completed a neuro check on Resident #26 and found Resident #26 had no drift (inability to maintain a static position), smiled appropriately, had no slurred speech, and pupils were reactive to light. Per interview, the neuro check was not alarming and Resident #26 gave appropriate responses.

Review of the APRN's assessment of Resident #26, on 07/17/15, revealed the chief complaint was a headache. Per the APRN's assessment, the resident was transferred from the discharging

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facility with complaints of a headache. Per the note, during transportation, Resident #26 fell out of the scooter. Resident #26 stated he/she did not hit their head, only hit their bottom. Resident #26 reported he/she had chronic headaches and had one before they left the facility. The resident had no complaints of dizziness or nausea or vomiting. Resident #26 stated he/she had not received a pain pill. Review of the documents sent with Resident #26 stated the resident had a long history of headaches and a recent change of Migraine medications. A headache was reported on the left side with a pain level of six (6) out ten (10). There were no vision changes reported by the resident. Vitals signs were obtained as followed; blood pressure 140/86; pulse 78; temperature 98.2; and, oxygen saturation was 98 percent (%). Resident #26 was assessed as alert and oriented times three (3) (person, place and time).

Review of Resident #26's Admission Assessment, dated 07/17/15 at 12:45 PM, revealed no identified skin concerns. Resident #26 verbalized a pain score of nine (9) out of ten (10), caused from the resident's headache, which felt severe, constant, aching and affected his/her day to day activities.

Further review of the resident's clinical record revealed no documentation of the resident's fall, nor completion of SBAR form at the time of admission to the facility. Even though the facility's policy and procedure stated the Change in Condition Report - Post Fall/Trauma would be initiated, there was no documented evidence this report was completed.

Interview with the ADON, on 08/13/15 at 5:00 PM,

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revealed there was no SBAR completed after the fall occurred and there should have been one.

Interview with the Licensed Practical Nurse (LPN) #9, on 08/14/15 at 2:15 PM, revealed when Resident #26 was admitted, the Unit Manager helped with Resident #26's admission. LPN #9 stated she obtained vitals for the Unit Manager and placed some medications into the computer system. LPN #9 stated she remembered giving report to the oncoming nurse about a fall with a transfer and the fact that Resident #26 hit her head. LPN #9 stated this was reported to her by the Unit Manager. LPN #9 stated she did complete a pain assessment on Resident #26 and administered scheduled Baclofen for muscle spasms, but no neuro checks were documented.

Interview with Registered Nurse (RN) #5, on 08/14/15 at 9:40 AM, revealed she took report from LPN #9 and did not recall any information about Resident #26 having a fall. RN #5 stated when she received her change of shift report, LPN #11 working as a Certified Nursing Assistant (CNA) the day of the incident, stated Resident #26 was looking for his/her nurse. When RN #5 approached Resident #26 he/she complained of a horrible headache and that the previous nurse gave him/her medication for pain at 2:00 PM and it was not working. Resident #26 stated he/she was starting to feel nauseated. Resident #26 then asked RN #5 could he/she have his/her Phenergan (anti-nausea medication). RN #5 administered the Phenergan dose and encouraged Resident #26 to lay down and place a cold wash cloth on his/her head. RN #5 stated fifteen (15) to twenty (20) minutes later while she was at her medication cart, LPN #11 approached RN #5 and stated Resident #26 was vomiting in a

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garbage can. RN #5 entered Resident #26's room and observed Resident #26 with dry heaves and a small amount of vomit in the garbage can. Once the resident calmed down, RN #5 stated she went to review Resident #26's chart and found Resident #26 had a history of Migraines, and a Shunt with Hydrocephalus and Spina Bifida.

Continued interview with RN #5, on 08/14/15 at 9:40 AM, she asked Resident #26 if the headache felt like one of his/her migraines and Resident #26 stated "No". When asked where the pain was coming from, Resident #26 stated the whole left side of his/her face, head and neck area. RN #5 asked Resident #26 if anything had happened that day and did Resident #26 hit his/her head. Resident #26 stated he/she fell earlier in the day. RN #5 asked Resident #26 if he/she had sustained a fall in the facility. Resident #26 stated "No". The RN further questioned the resident if he/she fell at the other facility. Resident #26 stated "No". Resident #26 stated when the van was turning a corner, his/her scooter fell over in the van. RN #5 asked when the scooter fell over in the van did the resident hit their head. Resident #26 stated "No", he/she would have remembered that, but it jarred him/her pretty good. Resident #26 stated he/she thought they needed to go to the hospital. RN #5 obtained Resident #26's blood pressure as 178/116.

Continued interview with RN #5, on 08/14/15 at 9:40 AM, revealed she completed a neurological (neuro) check on Resident #26 and found that his/her pupils were reactive to light, and no weakness in the extremities. However, review of Resident #26's record revealed only one (1)

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neuro check was completed by the APRN on 07/17/15 with no time documented.

Continued interview with RN #5, on 08/14/15 at 9:40 AM, revealed she could not remember if she wrote an order to send Resident #26 to the hospital. RN #5 stated Resident #26 was sent to the hospital about 4:15 PM to 4:30 PM for treatment.

Interview with the ADON, on 08/13/15 at 5:00 PM, revealed there was no Physician order to send Resident #26 out to the Emergency Room.

Review of the twenty-four (24) hour report, dated 07/17/14, revealed only that Resident #26 was admitted from another facility on the 7-3 shift. There was no record of a fall or special instructions for monitoring Resident #26's shunt.

Interview with the DON, on 08/21/15 at 2:29 PM, revealed she had not recognized that the order for transport to the hospital was not written or the fact that there was no SBAR for the fall.

Review of Resident #26's SBAR, completed after the resident was transferred to the hospital for complaints of pain, dated 07/17/15 at 4:29 PM, revealed Resident #26 complained of severe headache, nausea and vomiting with left side of head, face and neck pain, vomiting, and the skin was cool and clammy. Vitals signs were: blood pressure 176/118; temperature 97.6; pulse 70; and, respirations 16. Resident #26 requested to be sent to the hospital.

Review of Resident #26's Emergency Room visit, on 07/17/15 at 5:32 PM, revealed Resident #26 presented with a sharp, throbbing headache, pain

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rated at a nine (9) out of a one (1) to ten (10) pain scale. The resident stated that he/she was on his/her mobility scooter in van when his/her husband went around a corner, causing his/her scooter to tip over. Resident #26 stated that he/she struck his/her head. The resident was on his/her way to a new nursing home. The resident also complained of pain radiating down the neck, nausea and vomiting six (6) times, photophobia (abnormal intolerance to visual perception of light), and phonophobia (fear of loud sounds). Resident #26 developed a left hemispheric subdural hematoma measuring up to one (1) centimeter (cm) in maximal thickness.

Review of the Discharge Summary from the hospital, revealed Resident #26 expired on 08/01/15 at 3:00 PM related to complications with the subdural hematoma.

Interview with the Medical Doctor, who completed the hospital Discharge Summary, on 08/21/15 at 9:09 AM, revealed Resident #26 sustained a Post Traumatic Subdural Hematoma which played a role in Resident #26's decline. The pain radiating down his/her neck and complaints of nausea and vomiting were contributed by his/her fall and the hematoma he/she sustained. The cause of Resident #26's death was related to the hematoma. The Medical Doctor stated Resident #26 sustained an Acute Hematoma which meant it occurred the day of admission.

Interview with the Medical Director, on 08/13/15 at 3:05 PM, revealed the Administrator informed him of the accident that occurred with Resident #26. The clamps came undone on the scooter and Resident #26 fell in the facility van. The Medical Director stated he was told by the

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Administrator that Resident #26 had hit his/her head, which caused a subdural hematoma. He stated with the resident having a Hydrocephalic diagnosis increased Resident #26's risk for bleeding. Also the fact that Resident #26 was on a medication called Plavix also heightened the residents risk for bleeding.

Interview with the Administrator, on 08/14/15 at 1:00 PM, revealed she found out about the fall from the ADON and the Maintenance Director. Both of them informed the Administrator that they heard a noise, turned around and saw that Resident #26 was on the floor of the van. The scooter was still in its up right position and Resident #26 was found sitting beside the scooter on the floor. The Administrator stated the ADON assessed Resident #26 and the resident stated he/she did not hit their head. However, per interview with the Medical Director, the Administrator had told him the resident hit their head.

Further interview with the Administrator, on 08/14/15 at 3:20 PM, revealed the ADON and Maintenance Director asked Unsampled Resident G if Resident #26 hit his/her head and he/she stated "no" and Unsampled Resident G stated he/she witnessed the fall. The Administrator stated the ADON felt that the fall was witnessed because Unsampled Resident G stated he/she saw the fall. However, interview with Unsampled Resident G revealed the resident did not witness Resident #26 fall.

Continued interview with the Administrator, on 08/14/15 at 3:20 PM, revealed Resident #26 was alert and oriented times three (3) (person, place and time) and he/she also stated he/she did not

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hit their head. The Administrator stated a resident or visitor could be a witness to a fall. The Administrator did not obtain any statements from the two (2) residents who were transported in the facility van.

Continued interview with RN #5, on 08/14/15 at 9:40 AM, revealed when a fall occurred, she was to make sure the resident was okay, look for injuries, identify what happened when the fall occurred and what caused the fall. She would try to identify if the resident hit their head and if the resident did hit their head, they were to get another nurse and assess the resident. RN #5 stated if a fall was not witnessed the nursing staff must assume that the resident could have hit their head, and neuro checks were to be initiated. However, RN #5 revealed LPN #9 did not report to her that Resident #26 was to have neuro checks.

Interview with the APRN, on 08/13/15 at 10:11 AM and on 08/14/15 at 12:50 PM, revealed it was the facility's practice to do neuro checks on unwitnessed falls. He believed the ADON informed him Resident #26 fell on their bottom and that the fall was witnessed. The APRN stated if the fall was unwitnessed he would have encouraged the nurses to complete neuro checks because of the shunt.

Further interview with RN #5, on 08/14/15 at 9:40 AM, revealed the ADON came to the nurses station asking about Resident #26 and stated that it was scary what happened to Resident #26. The ADON stated when the van went to turn a corner or curve Resident #26 fell over with his/her scooter.

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Continued interview with the Administrator, on 08/14/15 at 3:20 PM, revealed the fall process was to assess the resident, notify the family and doctor, fill out an incident report, SBAR and a post fall report. These forms go to the morning meeting and the morning meeting staff review what happened, what interventions were put into place to prevent the accident from happening again. The Administrator stated she was not in the facility when the team (consisting of the DON, ADON, Activities, Nursing Managers, Dietary and Social Services) went over the investigation. The Administrator stated the team looked to see if notifications were completed. She stated it was hard to complete an investigation with the resident not present in the building. The facility could not provide any recommendations made by the team for Resident #26's fall.

Review of the facility's investigation, dated 07/17/15 at 12:15 PM, revealed it contain only statements from the ADON and the Maintenance Directors. There were no statements from Unsampled Residents F or Unsampled Resident G. Further review revealed no documented evidence the facility investigated the incident to determine the root cause of the fall.

Interview with the DON, on 08/21/15 at 2:29 PM, revealed it was the Administrator's responsibility to identify if the accident involving Resident #26 needed to be reviewed more closely.

Review of the facility's Resident Transport Policy, dated 08/01/11, revealed the purpose of the policy was to promote the safety of residents during transport in company vehicles and to minimize resident injury associated with vehicle accidents. All vans used to transport residents

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were required to be equipped with the QRT (no definition) "Restraint" System as manufactured by Q'Straint. The written instruction sheet would be placed on a clipboard or in a plastic sleeve for easy reference at all times. All resident wheelchairs would be secured using the QRT "Restraint" system and all residents would be secured with the lap and shoulder restraint before movement of the van. All van drivers and assistants would be trained using the instruction material and video before transporting residents in the van. Training would include a demonstration of the use of the restraint system. Initial and annual training would be documented and placed in the employees personnel file.

Review of the QRT Securement system, by Q-Restraint, revealed step 1: was to ensure the belt was in a straight line from anchor to wheelchair. Step 2: attach lap and shoulder belt. Never rely on the chair's own lap belt unless it was an approved occupant restraint. Q-Restraint recommended Tri-wheeler users be transferred to an ambulatory seat.

Interview with the Maintenance Director, on 08/13/15 at 4:40 PM, revealed Resident #26's scooter did not tip over in the van because of the one (1) wheel to the front of the scooter. He stated when he attached the belts to the one (1) wheel, the belts were tight. There was no conversation with the ADON about how to place belts onto the residents wheelchair. The Maintenance Director stated nothing happened on the van to cause Resident #26 to fall.

However, further interview with the Maintenance Director, on 08/13/15 at 3:30 PM, revealed Resident #26 fell out of his/her scooter and the

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scooter stayed secured. The Maintenance Director stated he was not trained on the use of the belts when he transported Resident #26 in the van. He stated he did not use a seat belt to secure Resident #26 in his/her seat, nor the belts that were provided on the van. He stated he received training about a week or two after Resident #26's fall.

Interview with the ADON, on 08/13/15 at 5:00 PM, revealed she had not been trained or in-serviced on the van and had not been on the van before 07/17/15.

Interview with the Activity Director, on 08/13/15 at 3:52 PM, revealed she had been driving the van for one (1) year and two (2) months. The Activity Director stated she was asked to make sure staff were trained, after the fall with Resident #26. The Activity Director stated when a resident was in a three (3) wheel scooter the resident should be transferred to a seat and the scooter locked because the three (3) wheel scooter was hard to secure.

Interview with the Administrator, on 08/14/15 at 1:00 PM, revealed prior to the transport on 07/17/15, she had not asked the Maintenance Director if he was trained on the use of the van and she was not sure if he was trained on the use of the belts on the van. The Administrator stated the thought never crossed her mind to ask those questions.

Review of the Maintenance Director's driving record, revealed he had a valid drivers license and no accident violations. There was no record of the video training or any other van training until after the incident occurred.

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Review of the Summary Report of Meeting Lecture, dated 07/28/15 after the incident with Resident #26, revealed the Maintenance Director was educated on transporting residents in the facility van. All residents must be secured properly in seat belts. All wheelchairs must be secured properly. If the electric scooter did not fit in the wheelchair lock down, then the resident must be transferred into a wheelchair that did fit for transport. The ADON's signature was not present on the meeting report summary as being trained.

Interview with the DON, on 08/21/15 at 2:29 PM, revealed she was the staff member who came up with the Lecture for the Maintenance Director as it related to transporting residents on the facility van. The DON stated she was not sure if the tie down to the wheels was good enough or secure enough when she wrote the lecture. The DON stated she held the training on the transporting of residents because she recognized there was a potential to affect other residents. The Maintenance Director was educated to transfer the resident out of the scooter into a chair.

2. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 02/27/14 with diagnoses of Communicating Hydrocephalus, Diabetes Type II, Disorganized type Schizophrenia, and Acquired Hemolytic Anemia's.

Review of the Annual Minimum Data Set (MDS) Assessment for Resident #3, dated 02/25/15, revealed the Care Area Assessment Summary triggered falls as an area of concern that may warrant interventions. The Quarterly MDS dated

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06/08/15, revealed the facility assessed Resident #3 to be totally dependent on staff for his/her Activities of Daily Living and totally dependent on staff for transfers. The resident scored a ten (10) out of fifteen (15) on the Brief Interview for Mental Status meaning the resident was interviewable.

Review of Resident #3's Comprehensive Care Plan last revised on 08/11/15 with a target date of 09/28/15, revealed the resident had a history of falls, and impaired mobility. He/she was to have bilateral fall mats and a tab alarm to his/her wheel chair. These assistive devices were initiated on 11/11/14.

Review of the Falls Incident Reports revealed Resident #3 had a non-injurious fall on 03/15/15, when he/she tried to get out of bed unassisted, on 05/11/15, after he/she rolled out of bed, and on 05/15/15, when he/she was trying to get out of bed unassisted.

Observations of Resident #3, on 08/11/15 at 1:40 PM, 2:20 PM, 3:05 PM, 5:10 PM, and on 08/12/15 at 12:10 PM, and 1:15 PM, revealed the resident did not have an alarm on his/her wheelchair while sitting in it watching television.

Observations of Resident #3, on 08/12/15 at 7:45 AM, 09:00 AM, and 10:00 AM, revealed the resident was in bed and there were no fall mats on either side of the resident's bed.

Interview, on 08/12/15 at 1:15 PM, with Resident #3 revealed the resident did not remember the last time he/she saw fall mats or a wheel chair alarm in his/her room.

Interview, on 08/13/15 at 9:45 AM, with CNA #1

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revealed she did not know where Resident #3's wheelchair alarm or fall mats were or when she last saw them. She stated she was aware of Resident #3's history of falls. She stated fall mats were used to prevent injury from falls and wheelchair alarms alerted staff when a resident tried to get up unassisted. She further stated she looked at the CNA care guide to see what assistive devices a resident needed.

However, review of the CNA care guide, not dated, revealed Resident #3 was a fall risk, utilized a chair and bed alarm, but there was no mention of the fall mats to be used.

Interview, on 08/13/15 at 2:30 PM, with LPN #1 revealed she remembered Resident #3's wheelchair alarm sounding on either 08/09/15 or 08/10/15 when the resident leaned forward to reach for the television remote control. She further stated she was pretty sure she remembered the fall mats being on the floor at the same time. She stated she was aware of Resident #3's fall history. LPN #1 verified the assistive devices were not in the resident's room and stated she did not know where the assistive devices were located.

Interview, on 08/14/15 at 7:25 AM, with MDS Nurse #1 revealed fall mats and wheel chair alarms were nursing interventions added to care plans after a resident's fall. She stated if fall mats and wheelchair alarms were on Resident #3's care plan, then they should be in the resident's room.

Interview, on 08/14/15 at 8:32 AM, with the ADON revealed the Unit Managers ensured assistive devices were in place for residents when they do

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their rounds on the unit. She stated assistive devices listed on the resident's care plan should be reflected in the resident's room. She stated fall mats helped prevent injuries from falls and wheel chair alarms alerted staff when a resident attempted to transfer unassisted.

The facility alleged the removal of Immediate Jeopardy by implementing the following:

1. On 07/17/15 Resident #26 was assessed by the Assistant Director of Nursing at approximately 12:15 PM for any injuries/pain at the time of incident.

2. On 07/17/15 at 12:40 PM, the Advanced Registered Nurse Practitioner assessed Resident #26 for signs of trauma.

3. On 07/17/15, the Assistant Director of Nursing notified the Executive Director of the fall Resident #26 had sustained and that an investigation into the incident had started.

4. On 07/17/15, the Executive Director interviewed the Maintenance Director, the Assistant Director of Nursing and another resident riding on the bus.

5. On 07/17/15 at 12:45 PM, the Licensed Practical Charge Nurse conducted an assessment of Resident #26.

6. The Registered Charge Nurse notified the Advanced Registered Nurse Practitioner of Resident #26's change in condition, at 4:00 PM on 07/17/15, and received an order to transfer the resident to the hospital for an evaluation.

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7. The Assistant Director of Nursing reviewed reports of falls that occurred within the first twenty-four hours of admission. The Assistant Director of Nursing's review of the reports determined four residents had sustained falls within twenty-four hours of admission.

8. The four resident's identified, that fell within twenty-four hours of admission, had their medical record reviewed by the Assistant Director of Nursing for timeliness of assessment and for the immediate development of the plan of care to meet the needs of the residents. The Assistant Director of Nursing determined the four resident's medical records contained a timely assessment and a plan of care.

9. The Director of Nursing and the Assistant Director of Nursing initiated an in-service education on, 08/21/15 and 08/25/15, for all full and part-time licensed nursing staff; 49 in total were trained. The training included: conducting resident admission assessments, creating the Immediate Plan of Care, updating care plans and Certified Nursing Assistant assignment sheets. In addition, the in-service covered timely completion of incident reports and documentation of changes in a resident's condition via the Situation, Background, Assessment, and Response (SBAR) model for documenting, and Physician and Family Notifications. The facility noted no other nurses would be allowed to work without first receiving this training.

10. The Clinical Liaisons (CL), which included Registered Nurses or Licensed Practical Nurses, would review potential resident admissions' for special needs, interventions, or equipment. From the review the facility would plan the resident's

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admission to ensure the identified needs, interventions or equipment would be in place at the time of admission, which included communicating the resident's needs to the Unit Managers.

11. The Unit Managers would ensure that the interventions, special needs or equipment were in place on admission, the care plan would reflect this information, and staff would be trained on resident care needs.

12. New resident admissions were reviewed in clinical morning meeting by the Unit Managers to ensure assessment, plan of care and documentation had been completed timely and accurately.

13. The facility policies titled: Accident Investigation, dated 06/17/15; Accident Investigation, Cause(s) of Accidents, dated 07/07/15; Interdisciplinary Care Plan, dated 02/26/15, and Resident Transport Policy, dated 08/01/11, were reviewed by the Executive Director, the Assistant Director of Nursing, and the Activities Director on 08/23/15 and it was determined no policy changes were needed.

14. After Resident #26's fall and before continuing to drive to the facility, the Maintenance Director verified the seatbelts and wheelchair restraint systems were in place for two (2) additional residents on the van with Resident #26.

15. The Maintenance Director and all facility personnel authorized to transport residents in the facility's van received training on the facility van's wheelchair lock-down system and on the Resident Transport Policy on 07/28/15. The

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training was provided by the facility's Activities Director.

16. Facility personnel authorized to transport residents would be retrained quarterly for four (4) quarters and annually, thereafter.

17. Safe resident transport would be based on the residents' individual needs. The Activities Director would review a resident's assessments and have discussion with the resident's charge nurse regarding the best ways to safely transport the resident.

18. The Human Resources Generalist and the Executive Director reviewed the files of personnel authorized to transport residents in the facility's van to ensure training and competencies were completed. In addition, these employees' files would be audited quarterly for four (4) quarters and then annually.

19. The Quality Assurance Performance Improvement Committee met on 08/23/15 with the following staff persons in attendance: Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Social Worker, Unit Managers, Director of Resident Assessment, Human Resources Generalist, Maintenance Director, Corporate Director of Clinical Education, and the Medical Director to review assessments and monitoring tools.

The State Survey Agency validated the removal of Immediate Jeopardy on 08/29/15 as follows:

1. Interview, on 09/02/15 at 2:20 PM with the Assistant Director of Nursing, revealed Resident #26 was assessed immediately at the time of

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his/her fall in the van.

2. Review of the Advanced Registered Nurse Practitioner's documented assessment, dated 07/17/15, revealed Resident #26 was assessed by the ARNP.

3. Interview with the Executive Director, on 09/02/15 at 2:00 PM, revealed the Executive Director was notified of the incident on 07/17/15 by the Assistant Director of Nursing. Review of the Verification of Investigation, revealed investigation of the incident was initiated on 07/17/15.

4. Interview with the Executive Director, on 09/02/15 at 2:00 PM, revealed on 07/17/15 the Executive Director interviewed the Maintenance Director, Assistant Director of Nursing and another resident who had been on the bus, as she initiated an investigation of the incident.

5. Review of the admission assessment titled Clinical Health Status, dated 07/17/15, revealed an assessment of Resident #26 was conducted.

6. Review of the Medication Administration Record and the Clinical Nursing Note for Resident #26, dated 07/17/15, timed 3:30 PM, revealed the resident received Promethazine 12.5 milligrams for nausea and vomiting. Further review of the clinical nursing note revealed the Registered Nurse in charge notified the Advanced Registered Nurse Practitioner of Resident #26's change in condition, at 4:00 PM on 07/17/15, and received an order to transfer the resident to the hospital for an evaluation.

7. Review of an aggregate list of resident falls,

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titled Total Events by Type, dated 02/22/15 to 08/22/15, revealed the facility's Assistant Director of Nursing identified four (4) residents, in addition to Resident #26, who had fallen within twenty-four (24) hours of their admission to the facility.

8. Interview, on 08/29/15 at 3:42 PM with the Assistant Director of Nursing, revealed upon review of the records of the four (4) residents who fell within 24-hours of admission, all were non-injury falls and none of the four (4) residents required transfer to the hospital for evaluation. The Assistant Director of Nursing stated she reviewed the time of day each resident was admitted to the facility and their diagnoses. The Assistant Director of Nursing stated she also reviewed the residents' physician orders/prescribed medications, and admission assessments.

Interview, on 08/29/15 at 2:50 PM with the MDS Coordinator revealed she reviewed care plans of the four (4) residents identified with falls within twenty-four (24) hours of admission, and determined the residents' care plans did not need to be updated.

9. Review of the document titled, Summary Report of Meeting: Nursing Lecture, Dated 08/21/15, revealed the facility's Director of Nursing and Assistant Director of Nursing initiated in-service education on 08/21/15 for the licensed nursing staff on resident admission assessments, creating the Immediate Plan of Care (IPOC), updating care plans and updating Certified Nursing Assistant assignment sheets. In addition, the in-service covered timely completion of incident reports and documentation of changes in a resident's condition using the Situation

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Background Assessment Response (SBAR) model for documentation, and on Physician/Family notifications.

Review of the document titled, Summary Report of Meeting: Nursing Lecture, dated 08/21/15, revealed the training was provided to forty-nine (49) licensed nurses and had signed they received the training.

Interview, on 08/29/15 at 1:20 PM with the Executive Director, revealed there were 49 nurses employed by the facility who were currently authorized to work on the nursing units, and all had completed the required training.

Interview on 08/29/15 at 3:05 PM with the Corporate Director of Clinical Services revealed the facility's Director of Nursing and Assistant Director of Nursing had been trained on conducting Resident Admission Assessments, creating the IPOC, updating care plans and Certified Nursing Assistant assignment sheets. The Corporate Director of Clinical Services stated this training also included documentation using the SBAR method when there was a change in a resident's condition, and completion of incident reports.

Review, of the sign-in sheet for the training provided by the Corporate Director of Clinical Services revealed facility's Director of Nursing and Assistant Director of Nursing signed that they attended the training.

Interview, on 08/29/15 at 3:42 PM with the Assistant Director of Nursing, revealed newly hired licensed nurses would receive training on completing admission assessments, creating the

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IPOC, updating the Certified Nursing Assistant care assignments, documenting via the SBAR when there was a change in a resident's condition, and completing incident reports. Nurses would not work on the nursing units until they had completed the training.

Interview, on 08/29/15 at 2:32 PM with Licensed Practical Nurse #14, revealed she received training within the past week on admission assessments, completing incident reports and documenting using the SBAR method when there was a change in a resident's condition. Licensed Practical Nurse #14 stated, when she admitted a resident, her responsibilities included obtaining necessary authorizations from the resident or his/her legal representative, conducting a resident assessment, and initiating the resident's IPOC.

Interview, on 08/29/15 at 1:15 PM with the 400 Hallway Unit Manager (UM), revealed she received in-service education in the past week on admission assessments, completing incident reports and documenting using the SBAR method when there was a change in a resident's condition. The 400 Unit Manager stated when a resident was admitted to the 400 Hallway, she reviewed all admission paperwork received from other facilities and reviewed and in-put the orders obtained from the resident's physician. The 400 Hallway Unit Manager stated if not on duty at the time of an admission, she reviewed the resident's paper work and orders, and personally visited the resident upon her return to work.

Interview, on 08/29/15 at 3:13 PM with the 200 Unit Manager, revealed she received recent in-service education on conducting admission assessments, completing SBARs and incident

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reports. In addition, the 200 Hallway Unit Manager stated the 24-hour shift report was the mechanism used for recording and communicating information about a resident's status, any new care areas, and any changes in a resident's condition over the 24-hour period. The 200 Hallway Unit Manager stated she reviewed the 200 Hallway 24-hour report every morning to ensure continuity of reporting of the residents' status across all shifts.

Interview, on 08/29/15 at 2:50 PM with the MDS Coordinator revealed she received recent in-service education on care planning for newly admitted residents, and on how nurses were to complete the initial admission assessment packet. The Director of Resident Assessment stated she was also trained on completing incident reports and documenting using the SBAR method in clinical notes. The Director of Resident Assessment/Minimum Data Set Nurse stated if a resident experienced a change in condition, such as a fall, a licensed nurse should assess the resident, put immediate interventions in place to protect and/or treat the resident's injury, if any. The care plan should be updated and the documentation should also include the SBAR and a completed incident report. The Director of Resident Assessment/Minimum Data Set Nurse stated the incident report(s) were later reviewed by the Quality Assurance Committee.

10. Interview, on 08/29/15 at 4:30 PM with the facility's Executive Director, revealed the corporation's clinical liaisons conducted pre-admission assessments for potential residents. The Executive Director stated the clinical liaisons forwarded the assessments to her, and along with the Director of Nursing and/or

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Assistant Director of Nursing, and the Admissions Director, she reviewed the data to determine the level care the potential resident would require, and any special equipment or arrangements the facility would need to secure prior to the resident's admission.

11. Interview, on 08/29/15 at 1:15 PM with the 400 Unit Manager, revealed when a resident was admitted to the 400 Hallway, she reviewed all admission paperwork received from other facilities and reviewed and in-put the orders obtained from the resident's physician. She stated the residents' clinical records were reviewed ensure the care plan was initiated, and that the Certified Nursing Assistant Care Record assignments, and the care interventions were communicated to the staff. The 400 Hallway Unit Manager stated if not on duty at the time of an admission, she reviewed the resident's paper work and orders, and personally visited the resident upon her return to work.

12. Review, on 08/29/15 of the Resident Admission Monitoring Tool, revealed the facility had admitted eight (8) residents since 08/26/15. The residents' clinical records were reviewed by the facility's Unit Managers, who signed/dated when they reviewed the residents' records for plan of care, Certified Nursing Assistant Care Record assignments, and for implementation of the care interventions, as planned. According to the Unit Manager's signatures with dates, all eight (8) records had been reviewed for the required components within one (1) day of each resident's admission to the facility.

Interview, on 08/29/15 at 3:42 PM, with the Assistant Director of Nursing revealed she would

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be responsible for ensuring all components of the admission documentation was completed for newly admitted residents. The Assistant Director of Nursing stated the Unit Managers and the Minimum Data Set Nurses were also responsible for ensuring all necessary admission documentation was completed. In addition, the Assistant Director of Nursing stated she would review the new admission audits conducted by the Unit Managers, and these documents would be discussed daily in clinical morning meetings. The Assistant Director of Nursing stated, to date, no corrective action had not been necessary as the admission documentation has been completed for new admissions as required.

13. Interview, on 08/29/15 at 1:20 PM with the Executive Director, revealed she and the Assistant Director of Nursing reviewed following policies 08/23/15: Accident Investigation, dated 06/17/15; Accident Investigation, Cause (s) of Accidents, dated 07/07/15; and Interdisciplinary Care Plan, dated 02/26/15, no changes to the policies were made.

Interview, on 09/02/15 at 2:35 PM, with the Activities Director revealed she reviewed the Resident Transport Policy with the facility's Executive Director, and recently retrained the staff authorized to drive the facility's van.

14. Interview, on 09/02/15 at 3:20 PM with the facility's Maintenance Director, revealed once the Assistant Director of Nursing assessed Resident #26 after his/her fall on the van, he ensured Resident #26's wheelchair lock-down system and seatbelts were secured and fastened. In addition, the Maintenance Director stated he also observed the other two residents on the van to ensure their

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wheelchairs/safety belts were secured/fastened before moving the van.

15. Interview, on 09/02/15 at 2:35 PM with the Activities Director, revealed on 07/28/15, she retrained the facility's authorized van drivers on safe resident transport and proper use of the van's wheelchair lock-down system.

16. Review of the document titled, Quarterly Drivers Files Audit, No Date, revealed the drivers' files would be audited for re-training competencies on 10/28/15, 01/28/16, 04/28/16 and 07/28/16.

17. Interview, on 08/29/15 at 2:50 PM with the Director of Resident Assessment/MDS revealed, on 08/28/15, the Activities Director consulted with the Director Of Assessment/Minimum Data Set Nurse prior to transporting a resident who had a lap tray affixed to his/her wheelchair. The Director of Resident Assessment/Minimum Data Set Nurse stated she referred the Activities Director to Therapy Department as she thought therapy staff could best answer the question related to the resident's wheel chair tray.

18. Interview, on 08/29/15 at 3:22 PM with the Human Resources Generalist, revealed she reviewed the records for all authorized van drivers to ensure their drivers' licenses and Department of Transportation certifications were in-date, and for verification of re-training on the van's wheelchair restraint system. The Human Resources Generalist stated she was assigned to monitor the van drivers records for the required competencies and for verification of quarterly retraining for one year, and thereafter she would conduct an annual review of their records.

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F 323	Continued From page 75 19. Review of the document titled, Ad Hoc QAPI, dated 08/23/15, revealed the Executive Director, the Director of Nursing, the Assistant Director of Nursing, the facility's Social Worker, Unit Managers for four (4) of four (4) nursing units, the Director of Resident Assessment, the Human Resources Generalist, the Maintenance Director, the Corporate Director of Clinical Education, and the facility's Medical Director attended the QAPI meeting. Interview with the ADON, on 08/29/15 at 3:42 PM, revealed she would oversee the monitoring that would occur by the Unit Managers and MDS Nurses, for the new admission process, complete all proper documentation, all new admissions will be discussed during the daily clinical meetings, twenty-four hour reports would be reviewed at the clinical meeting. The ADON stated she would also be attending the QA meetings and providing progress of the monitoring process for admissions and changes of condition. Interview with the Administrator, on 08/29/15 at 4:30 PM, revealed nurses were assigned to monitor tasks described in the AOC to ensure that all residents newly admitted have been assessed and screened by the new process and interventions put in place. The Administrator stated she would have the AOC minder at each morning meeting to review and to check to ensure assigned staff were continuing to monitor for compliance with the plan.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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F 371	Continued From page 76 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to distribute food under sanitary conditions when serving food, for two (2) of twenty-six (26) residents (Residents #1 and #4). Observations revealed the Cook placed Resident #1's food on a wet plate from a stack of plates delivered to the tray line from the dish washing room after the plate warmer ran out of plates. In addition, interview with Resident #4 revealed they received adapted equipment that was still wet. The findings include: Review of the facility's policy regarding Washing Dishes, not dated, revealed the dietary staff was to allow all items to thoroughly dry before unloading or storing and to store all items completely free of moisture. Review of the facility's policy regarding Washing Flatware, not dated, revealed the dietary staff was to allow flatware to air-dry either by cylinder storage or bin storage.	F 371		

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F 371	Continued From page 77 Observation, on 08/12/15 at 10:45 AM, during the lunch tray line revealed the Dietary Cook took a wet plate from a stack of approximately 10 plates and placed food on the plate then placed the plate of food on a tray for Resident #1. Interview, on 08/13/15 at 2:35 PM, with Resident #4 revealed when his/her meal tray was delivered to his/her room, the adaptive equipment (foam handled fork and spoon) on the meal tray was sometimes wet to touch. Interview with the Dietary Cook, on 08/13/15 at 9:15 AM, revealed she had been trained on hire and at least once in the past year to allow the dishes and utensils to air dry before use. She stated by not letting the dishes air dry it could cause bacteria to grow on the dish and make the resident sick. She stated she realized she had plated food on a wet plate after she had already placed food on it. She stated she was nervous because a State and Federal surveyor were watching her and she had never used wet dishes or utensils in the past. Interview with the Dietary Manager, on 08/12/15 at 1:15 PM, revealed the facility policy stated to allow dishes and utensils to air dry before use. She stated the Dietary employees were trained upon hire and throughout each year on that policy which included air drying dishes and utensils. She also stated the potential harm for using wet dishes would be bacteria growing on the dishes and making the residents ill. She then stated this incident had never occurred in the past with any other Dietary staff member and the Dietary Cook was nervous because surveyors were observing her.	F 371		

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 431		

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by:
Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure one (1) of four (4) nursing units kept medications in a locked room. Three medication carts and one (1) treatment cart were stored in an unlocked room on the 300 Unit when not in use. In addition, the facility failed to ensure that one (1) emergency intravenous fluid for medication reconstitution was not expired and available for use.

The findings include:

Review of the facility's policy regarding Storage of Medication, dated 01/06/15, revealed in order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) would be allowed access to the medication carts. Medication rooms, cabinets and medication supplies were to be locked or attended by persons with authorized access. Continued review of this policy revealed outdated medications were to be immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order existed.

1. Observation, on 08/13/15 at 3:15 PM, revealed three (3) medication carts and one (1) treatment cart on the 300 Hallway were not stored in a locked room when not in use. The medication carts and the treatment cart were stored in a vacant resident room (Room 303), and there was

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no lock on the door. Resident Room 303 was near the end of the hallway away from the nurses' station which was located at the center of the 300 Hallway. In addition, this observation revealed one (1) of the three (3) medication carts stored in Room 303 was unlocked. Continued observation revealed the unlocked medication cart contained multiple doses of medications prescribed for residents in Rooms 300-310, and included, but was not limited to the following medications: Nitrostat 0.4 mg tablets; Glucagon Injection Pen (for treating hypoglycemia); Humulin R Insulin; Lasix 40 mg tablets; Fish Oil Capsules; Hydralazine 100 mg tablets; Warfarin 6 mg tablets; Namenda 10 mg tablets; Nystatin Oral Suspension; Senna Syrup 176 mg/5 milliliters (ml's); and Polyethylene Glycol Powder 255 GM Powder.

Interview, on 08/13/15 at 3:15 PM, with the Unit Manager (UM) for the 300 Unit revealed she did not think the entry door to Room 303 was in full view of staff that worked at the nurses' station, and this prevented the nursing staff from being able to continuously monitor this unlocked room. The UM stated until about one (1) month ago, the medication and treatment carts were stored in a locked room next door to the nurses' station, but that room was converted to the Director of Nurse's (DON's) office, and the carts were then stored in whatever resident room happened to be vacant. The UM stated the carts were stored in Room 303 for about one (1) week. Prior to that, the medication carts and treatment cart had been stored in vacant Resident Room 326, which was also kept unlocked. The UM stated Room 326 was closer to the nurses' station. The UM stated the Administrator made the decision to use

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vacant resident rooms as storage areas for the medication carts/treatment carts. Continued interview with the UM revealed there were typically two (2) licensed nurses on duty each shift. The UM stated all licensed nurses were trained to ensure medication and treatment carts were locked when they were not in direct sight of the nurses assigned to them, but she did not think the 300 Unit nurses received additional in-service education related to increased monitoring of the medication/treatment carts while they were stored in the vacant/unlocked resident rooms.

Interview, on 08/13/15 at 4:20 PM, with Incensed Practical Nurse LPN #5 revealed nurses were to ensure medication and treatment carts remained locked when not in use. LPN #5 stated she found her assigned medication cart in the vacant resident Room 303 today when she reported to work. LPN #5 stated she did not routinely work on the 300 Unit, but she had worked the unit a few times over the past two (2) weeks. LPN #5 stated she had not seen any residents attempt to enter vacant room 303 where the medication/treatment carts were stored.

Interview, on 08/13/15 at 4:50 PM, with Certified Nursing Assistant (CNA) #2, revealed he typically worked on the 300 Unit, and had not seen any residents enter vacant Room 303 where the medication/treatment carts were stored. CNA #2 stated a couple of residents from other hallways in the facility occasionally came to the 300 Unit looking for refreshments in the 300 Unit refrigerator, but he had not seen them attempt to enter vacant Room 303.

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F 431	Continued From page 82 Observation, on 08/13/15 at 4:55 PM, revealed the medication carts and the treatment cart for the 300 Unit had been moved to the lockable room next to the nurses' station. Interview, on 08/13/15 at 4:45 PM, with the Assistant Director of Nursing (ADON) revealed she was aware the medication carts and the treatment cart for the 300 Unit had been stored in various vacant resident rooms. The ADON stated she was also aware there was a plan to find a more secure space for the carts, but the storage of the carts in an unlocked space concerned her because residents, visitors, and staff not authorized to administer medications would have access to the contents of the medication/treatment carts if they were left unlocked. The ADON stated it could be potentially harmful if residents' obtained and ingested medications that were not prescribed for them. Continued interview with the ADON revealed, to date, there had not been any incidents where residents had obtained medications from unlocked medication carts or treatment carts. 2. Observation, on 08/12/15 at 9:51 AM, of the emergency medication supply stored in the medication room on the 200 Unit, revealed one (1) vial of Meropenem 500 milligram (expiration date January 2016) packaged with a 50 milliliter bag of Sodium Chloride 0.9%, with an expiration date of July 2015. Interview, on 08/12/15 at 10:20 AM, with the Unit Manager (UM) for the 200 Unit revealed the 200	F 431		

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F 431	Continued From page 83 Unit medication room was the storage area for the emergency intravenous medications supply for all nursing units in the facility. The UM stated nursing staff for the 100, 300 and 400 Units would obtain emergency intravenous medications and fluids from the 200 Unit stock until the physician's order could be filled and delivered by the pharmacy. The UM stated the emergency medication supplies were audited every two (2) weeks by staff from the contracted pharmacy, but the UM could not identify any facility staff person assigned to perform audits of the emergency medications to ensure the supplies were not expired. The UM also stated that it was not good practice to use expired products for the administration of medications, and in-date products should always used to ensure effective administration of the medications.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

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F 441	Continued From page 84 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This STANDARD is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to maintain an Infection Control Program for four (4) of twenty-six (26) sampled residents and one (1) of five (5) unsampled residents. Breaches in infection control were observed during wound care and dressing changes for Residents #2, #4, #5, #12 and #13 and Unsampled Resident E. In addition, nurses were observed not sanitizing their hands and not using proper handwashing technique during the medication pass observation, and five (5) of the ten (10) pill crushers on the medication carts were soiled. Staff was also observed obtaining disposable gloves from an unclean area for use	F 441		

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during a meal tray pass on the 300 Unit.

The findings include:

Review of the facility's policy regarding Handwashing/Hand Hygiene, revised August 2014, revealed all personnel would follow handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. Staff was to wash their hands before preparing or handling medications, after contact with a resident's intact skin, and after contact with objects in the immediate vicinity of the resident. The steps for handwashing were also listed in the policy and included turning off the faucet handles with a clean paper towel as a final step in the handwashing procedure. In addition, when donning clean disposable gloves, the gloves were to be obtained from a dispensing box, one glove at a time, touching only the top of the cuff.

1. Observation, on 08/12/15 at 9:07 AM, during the morning medication pass on the 200 Unit, revealed Licensed Practical Nurse (LPN) #3 did not wash her hands or use hand sanitizer after administering medication to Unsampled Resident B, but proceeded to set up medications at the medication cart for Unsampled Resident C, and then entered his/her room and administered the medication to that resident. LPN #3 did not sanitize her hands upon exiting Unsampled Resident C's and proceeded to knock on Resident Room 207, entered the room, and closed the door to that room.

Observation, on 08/13/15 at 8:56 AM, during the morning medication pass on the 100 Unit, revealed LPN #1 administered medication to

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Unsampled Resident D, went to the sink in the resident's room to wash her hands, used soap and water to cleanse her hands, but turned off the faucet handles with her bare hands. Observation also revealed the paper towel dispenser over the sink was empty. After turning off the faucet handles with her bare hands, LPN #1 crossed the hall to Resident Room 102 and obtained a paper towel from the dispenser in that room to dry her hands.

Observation, on 08/13/15 at 9:13 AM, during the morning medication pass on the 100 Unit, revealed LPN #2 assisted Resident #2 with a morning dose of his/her metered-dose inhaler. Before exiting the room, the nurse turned to wash her hands at the room's sink, realized the paper towel dispenser above the sink was empty, asked Resident #2's roommate if she could use some of his/her facial tissues to dry her hands, and used the tissues to dry her washed hands and turn off the sink's faucet handles.

Interview, on 08/13/15 at 9:15 AM, with LPN# 2 revealed there was usually enough paper towels in resident rooms for use and was not sure why the paper towel dispenser was empty.

Continued interview with LPN #2, on 08/14/15 at 8:40 AM, revealed the facility's Housekeeping Staff was responsible for ensuring resident rooms had paper towels, and she stated Housekeeping staff was on the unit throughout the day. LPN #2 stated she did use facial tissues obtained from Resident #2's roommate to dry her hands, but this was not ideal because of the increased risk of cross-contamination from using another resident's supplies.

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2. Review of the facility's policy regarding Crushed Medication Delivery, revised 02/01/11, revealed it was important to wipe down the inside of the pill crusher and removable grey overflow cup with a wet paper towel or other cleaning solution prior to use, and also before and after each med pass. The policy further stated this would help reduce static buildup, cross contamination, and ensure proper maintenance as required by the product's warranty.

Observations, on 08/12/15 at 8:45 AM, of the medication cart marked 230-1 revealed a pill crusher located on top of the medication cart had a brown crusted substance around the lid, and tan colored stains down the sides of the crusher.

Observation, on 08/13/15 at 8:42 AM, of the pill crusher on the 100 Unit medication cart for rooms 138-141, revealed a brown substance around the cup and ring area of the pill crusher.

Observation, on 08/14/15 at 9:28 AM, of the medication cart on the 400 Unit, revealed a soiled pill crusher with a brown substance around the rim and in the interior of the device where the disposable cups would be placed.

Observation, on 08/14/15 at 9:50 AM, on the 200 Unit revealed there was a soiled pill crusher with a brown substance on the medication cart for Rooms 200-229, and the pill crusher on the medication cart for Rooms 200-208 was also soiled with a brown substance.

Interview, on 08/14/15 at 2:50 PM, with the Assistant Director of Nursing (ADON) revealed medication carts and all equipment used for medication preparation should be cleaned on an

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as needed basis by the nurses assigned to the carts. The ADON stated the Unit Managers were responsible for monitoring the medication and treatment carts for cleanliness, but there was no specific schedule for cleaning the carts. The ADON stated it was important for all medication preparation equipment to be cleaned regularly to prevent cross-contamination and the spread of infection, and that she would expect the pill crushers on every med cart to be cleaned often.

3. Review of the facility's policy regarding Dressing Change-Clean, dated 01/30/15, revealed the nurse was to create a clean field with paper towels or a towelette drape.

Review of the clinical record for Resident #4 revealed the facility admitted the resident on 01/21/15 with diagnoses of Diabetes Type 2, Hypo-potassium, Paraplegia, Decubitus Ulcers, Generalized Anxiety Disorder, Esophageal Reflux, and Neurogenic Bladder. Resident #4 had orders for wound care/dressing changes twice daily to a wound on the posterior side of his/her right thigh and to a wound at the Achilles area of his/her right leg.

Observation, on 08/14/15 at 9:55 AM, during the skin assessment for Resident #4 revealed LPN #4 did not create a clean field for placement of the supplies used for the dressing change. The nurse placed the medications (Silva Sorb, Santyl, and Bacitracin), some tongue depressors, and the paper tape dispenser on a stack of folded towels that were atop the resident's over bed table. A bottle of spray-on wound cleanser was placed on the resident's bedside table not protected by a barrier, and some of the packaged

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dressings overlapped onto the resident's personal belongings that were also left on the overbed table. During the dressing changes, LPN #4 washed her hands three (3) times, but turned off the faucet handles each time using her bare hands, not with a clean paper towel.

Interview, on 08/14/15 at 12:45 PM, with LPN #4 revealed she realized she did not use a paper towel to turn off the faucet handles when she washed her hands before and during the dressing changes for Resident #4, and stated this probably occurred because she was nervous. LPN #4 stated she thought the stack of folded towels on Resident #4's overbed table served as the clean field/barrier for placement of supplies for the resident's wound care/dressing changes. LPN #4 stated she placed the bottle of wound cleanser on the overbed table, and saw the resident's personal belongings on the table, as well. LPN #4 stated the wound care dressing change for Resident #4 was not a sterile procedure, but was considered a clean procedure for wound care.

Interview, on 08/14/15 at 2:50 PM, with the ADON revealed nurses were to always use a clean paper towel to turn off faucet handles after washing their hands in order to prevent the risk of cross contamination to other residents, other staff, and themselves. The ADON stated the nurses should also keep hand sanitizer on their person for use when proper handwashing could not be completed immediately, and there were many hand sanitizer dispensers affixed to the walls on every hallway of the facility where direct care was performed.

4. Review of the medical record for Resident #12, revealed the facility admitted the resident

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most recently on 07/15/15 with diagnoses of Atrial Fibrillation, Dementia, and Kyphoplasty. Review of the Physician orders, dated 08/10/15, revealed staff was to clean incision sites to the lower back with peroxide and cover with a loose dressing two (2) times a day.

Observation, on 08/12/15 at 9:19 AM, revealed LPN #7 obtained a sterile package of 4X4s, sterile Q-tips, and Peroxide and placed them on the resident's bedside table. A clean field was not established. After she cleaned the wound with the Q-tips, she changed her gloves, but did not wash her hands between glove changes. After she completed the treatment and skin assessment, LPN #7 proceeded to take unused left over supplies back to the treatment cart. She did not wipe down the Peroxide bottle before placing it back in the treatment cart.

Interview, on 08/12/15 at 11:00 AM, with LPN #7 revealed she didn't think she had done anything wrong with the dressing change for Resident #12. She stated she did not remember if she needed to wash her hands between glove changes and could not remember if she had been trained on the dressing change policy. She stated she was not sure if it was okay to return unused supplies to the treatment cart.

Interview, on 08/14/15 at 4:30 PM, with the ADON in regards to infection control revealed resident rooms were considered dirty. She stated taking supplies from a dirty area, with out disinfecting them, then placing them in the treatment cart was a risk for contamination and infection. She stated the disposable supplies should have been discarded and not brought back to the treatment cart.

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5. Review of the medical record for Resident #5 revealed the facility admitted the resident on 07/09/15 with diagnoses of Hemiplegia, Deformed Right foot, and a Pressure Ulcer. Review of the Physicians orders, dated 08/11/15, revealed the staff was to clean the right outer foot with wound cleaner then apply Bacitracin ointment and cover with a dry dressing every day.

Observation, on 08/12/15 at 9:39 AM, revealed Registered Nurse (RN) #2 completed the dressing change to the right foot of Resident #5. No clean field was prepared. After removing the old dressing from the right foot, RN #2 removed his gloves and replaced them with another pair without washing his hands. RN #2 proceeded to use wound cleaner to clean the wound, laid the bottle on the resident's bed, then picked the bottle up and placed it on the table.

6. Review of Resident #13's clinical record revealed the facility admitted the resident on 08/08/15 with a diagnosis of Right Tibia and Fibula Fracture.

Observation of a dressing change, on 08/11/15 at 2:35 PM, revealed Licensed Practical Nurse (LPN) #3 removed the old dressing; removed the gloves; washed her hands; and, donned new gloves. LPN #3 cleaned Resident #13's staples with soap and normal saline; dabbed the wound dry with a towel; removed her gloves; did not wash her hands; donned new gloves; and, applied the abdominal pad to the staples and wrapped with Kerlix.

Interview with LPN #3, on 08/11/15 at 2:45 PM, revealed when she cleaned the wound her gloves

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were considered dirty and should have washed her hands when donning the new gloves.

Interview, on 08/14/15 at 2:50 PM, with the ADON revealed normally the DON would oversee the infection control program for the facility, but as ADON, she would oversee the program in the DON's absence. The ADON stated the facility had a Corporate Director of Clinical Education who periodically monitored nurses' competencies for direct care tasks such as dressing changes, but this mostly occurred when there was an identified increase in infections within the facility. The ADON stated the facility did not currently have a specific nurse assigned to monitor wound/care dressing change technique of licensed nurses.

7. Observation of the Tray pass on the 300 Unit, on 08/12/15 at 12:02 PM, revealed Certified Nursing Assistant (CNA) #8 was donning Personal Protective Equipment (PPE), before entering Unsampled Resident E's Room 327 which was an isolation room for C-Diff, to deliver a tray of food. CNA #8 removed a pair of gloves from LPN #7's pocket of her work uniform because there were no gloves in the isolation cart outside of Room 327.

Interview with CNA #8, on 08/12/15 at 12:02 PM, revealed the PPE equipment was supposed to be in the isolation cart. CNA #8 stated anything that touched her body was not considered clean and thus the gloves she removed from LPN #7's body was not considered clean.

Interview with LPN #7, on 08/12/15 at 12:10 PM, revealed the resident in Room 327 was on precautions for C-Diff. LPN #7 stated if the

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F 441	Continued From page 93 isolation cart was out of gloves the staff should get more gloves. LPN #7 stated she was aware her clothes were considered dirty and technically the gloves in her pocket were not considered clean either. LPN #7 stated her clothes were not considered clean because she frequently goes into resident rooms touching things. LPN #7 stated she could possibly contaminate other residents with the use of the dirty gloves.	F 441		
F 514 SS=J	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to have an effective system in place to maintain a complete and accurate clinical record, in accordance with professional standards, for one (1) of twenty-six (26) sampled residents (Resident #26).	F 514		

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On 07/17/15, Resident #26 fell from his/her wheelchair while riding in the facility's van, sustained a change in condition, and was transferred to an acute care hospital later that same day. Resident #26 was diagnosed with a subdural hematoma, and expired on 08/01/15 from complications. The facility's Assistant Director of Nursing (ADON), who assessed Resident #26 immediately after the fall, did not document her assessment in the resident's clinical record. The nurses failed to document any neuro-checks post incident and the nurses failed to document the Situation, Background, Assessment Report (SBAR).

The facility's failure to have an effective system in place to accurately and completely document in the resident's clinical record has caused or is likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 07/17/15 and the facility was notified on 08/21/15.

An acceptable Allegation of Compliance (AOC) was received on 08/28/15, alleging the removal of Immediate Jeopardy on 08/27/15. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 08/27/15 as alleged prior to exit on 08/29/15, which lowered the Scope and Severity to a "D" at 42 CFR 483.75 Administration (514) while the facility develops and implements the Plan of Correction (POC), and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.

The findings include:

The facility did not provide a policy for

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documentation in residents' clinical records.

Review of the clinical record for Resident #26 revealed the facility admitted the resident from another long term facility on 07/17/15. Resident #26 had diagnoses of Spina Bifida, Hydrocephalus with a shunt, Hypothyroidism, Nausea and Vomiting, Unspecified Essential Hypertension, and Chronic Headaches. Physician ordered medications were Plavix (to prevent blood clots) 75 mg daily, Aspirin (for pain, fever, and inflammation) 81 mg daily, and Maxalt 10 mg, as needed, for headache.

Further review of the clinical record for Resident #26 revealed during transport to the facility staff failed to secure the resident via all available safety restraints prior to beginning the transportation. The resident's three (3) wheel scooter tipped over during transport and the resident fell from the scooter. The resident was subsequently transferred to the Emergency Room on 07/17/15 with a diagnosis of Subdural Hematoma and expired on 08/01/15 from complications.

Record review revealed the ADON failed to follow the facility's policy and did not document the assessment completed after the fall. The facility also failed to complete and document the (SBAR) form for Resident #26 until the resident was sent to the hospital. Therefore, all nursing staff members were not aware of the fall or details related to the fall sustained by the resident.

Interview with the ADON, on 08/13/15 at 10:00 AM, revealed she was in the van when the resident fell from the scooter and she assessed Resident #26's range of motion.

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However, review of the nurses' notes, dated 07/17/15, revealed the ADON failed to complete the Situation, Background, Assessment, Response (SBAR) note to document Resident #26's fall from his/her wheelchair while riding in the facility's van.

Interview, on 09/03/15 at 4:35 PM, with the ADON revealed she did not document her observations and her assessment of Resident #26, as a first responder when the resident fell from his/her wheelchair on the van. The ADON further stated she probably should have documented her assessment in the resident's clinical record because it would have been important information for other staff as they conducted ongoing assessments, and planned subsequent care and made decisions for the necessary care after the resident's fall.

Interview with the Director of Nursing (DON), on 08/21/15 at 2:29 PM, revealed she had not recognized there was not an SBAR completed on the fall sustained by Resident #26. The DON stated there should have been an SBAR added to the resident's clinical record.

Interview with the Administrator, on 08/14/15 at 8:20 PM, revealed when a resident sustained a fall, the nurse was to assess the resident, and notify the physician and the family. The nurse would then complete an SBAR, a Verification of Investigation, and a Post Fall Analysis. Per interview, all of these forms were a permanent part of the resident's record.

Further interview, on 09/03/15 at 2:20 PM, with the ADON revealed in addition to checking

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Resident #26's range of motion, she also assessed the resident's pupils for equal size of reactivity to light stimulus, the resident's ability to grip with his/her hands, and his/her orientation to name and place. However, review of the clinical record revealed no documented evidence this assessment was conducted.

Continued interview, on 09/03/15 at 4:35 PM, with the ADON, revealed she would not consider Resident #26's clinical record complete since she failed to document her immediate observations and assessments of the resident after the resident fell from his/her wheelchair.

Further review of the clinical record revealed a nurse's note designated as a late entry, dated 07/17/15 at 1:30 PM, where the DON documented "resident was transferred to this facility from [another] Facility in bus when w/c tilted over enroute. Resident states that she did not hit her head but that she did have a migraine headache that she had prior to leaving [the other facility]. No other apparent injury noted. According to resident she has a h/o severe headaches/migraines."

Interview with the DON, on 08/21/15 at 2:29 PM, revealed she wrote the first nurse's note, (designated as a late entry on 07/17/15 at 1:30 PM) based on the information that she believed was told to her by the Unit Manager. The DON then recanted and stated she wrote the statement based on what she assumed happened. The DON stated she was just helping the admitting nurse by writing the nurse's note on the same day the incident occurred. The DON stated she was not supposed to write inaccurate information in the resident's record. The DON stated she may

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have used a poor choice of words by writing that Resident #26's wheelchair tilted over. The DON stated the Administrator confronted her and informed the DON that what she had documented was not what had happened to Resident #26, but that Resident #26 fell out of his/her wheelchair.

Interview with the Administrator, on 08/14/15 at 3:20 PM, revealed she was not aware the DON had documented in the nurse's notes that Resident #26 fell while in wheelchair. However, the DON's documentation stated the resident's wheelchair tilted over not that the resident fell.

Continued interview with the Administrator, on 08/14/15 at 3:20 PM, revealed the DON was wrong for documenting inaccurate information regarding the tilting of the three wheel scooter versus a fall from the scooter and she did not understand why the DON had documented in the nurse's note at all.

Further review of the SBAR/nurses note on 07/17/15 at 4:29 PM, revealed Resident #26 requested to be sent to the hospital. However, review of the clinical record revealed there was no Physician order to transfer the resident to the hospital.

Interview with Registered Nurse (RN) #5, on 08/14/15 at 9:40 AM, revealed she remembered talking to the APRN about Resident #26 requesting to the go to the hospital and that the APRN gave the directive to send Resident #26 out to the Hospital for treatment. RN #5 stated she could not remember writing an order or not. Per interview, she should have completed a SBAR and Data for Quality Improvement (DQI) related to the resident's change in condition prior

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to discharge. However, review of the clinical record revealed these forms were not completed at the time of transfer.

Interview with the Unit Manager of the 100 Hall, on 08/21/15 at 3:30 PM, revealed she was told by the DON to complete a DQI, but was not asked to complete an SBAR. She completed a DQI on Monday 07/20/15, three (3) days after the resident was transferred to the Hospital.

Interview with the ADON, on 08/13/15 at 5:00 PM, revealed she did not review the clinical record to determine if there was a SBAR completed for Resident #26 or if an order was written to send Resident #26 out to the hospital for evaluation and treatment on 07/17/15.

Continued interview, on 09/08/15 at 10:55 AM with the Administrator, revealed newly employed nurses received training from the Corporate clinical staff regarding the facility's expectations for clinical record documentation. The Administrator stated the ADON did not document her assessment of Resident #26 in the clinical record, but that she should have, so that all staff caring for the resident prior to his/her transfer to the hospital would have had access to the ADON's immediate observations and findings directly after the resident fell. The Administrator stated the process was for the team, during the morning meeting, to ensure all forms (SBAR, DQI, post fall analysis, and nurses notes) were completed, orders were obtained, and new interventions were placed on the care plan, and physician and families were notified. However, she was not in attendance at that meeting for Resident #26, and did not review to ensure the record was complete and accurate.

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The facility alleged the removal of Immediate Jeopardy by implementing the following:

1. On 07/17/15 Resident #26 was assessed by the Assistant Director of Nursing at approximately 12:15 PM for any injuries/pain at the time of incident.

2. On 07/17/15 at 12:40 PM, the Advanced Registered Nurse Practitioner assessed Resident #26 for signs of trauma.

3. On 07/17/15, the Assistant Director of Nursing notified the Executive Director of the fall Resident #26 had sustained and that an investigation into the incident had started.

4. On 07/17/15, the Executive Director interviewed the Maintenance Director, the Assistant Director of Nursing and another resident riding on the bus.

5. On 07/17/15 at 12:45 PM, the Licensed Practical Charge Nurse conducted an assessment of Resident #26.

6. The Registered Charge Nurse notified the Advanced Registered Nurse Practitioner of Resident #26's change in condition, at 4:00 PM on 07/17/15, and received an order to transfer the resident to the hospital for an evaluation.

7. The Assistant Director of Nursing reviewed reports of falls that occurred within the first twenty-four hours of admission. The Assistant Director of Nursing's review of the reports determined four residents had sustained falls within twenty-four hours of admission.

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F 514	Continued From page 101 8. The four resident's identified, that fell within twenty-four hours of admission, had their medical record reviewed by the Assistant Director of Nursing for timeliness of assessment and for the immediate development of the plan of care to meet the needs of the residents. The Assistant Director of Nursing determined the four resident's medical records contained a timely assessment and a plan of care. 9. The Director of Nursing and the Assistant Director of Nursing initiated an in-service education on, 08/21/15 and 08/25/15, for all full and part-time licensed nursing staff; 49 in total were trained. The training included: conducting resident admission assessments, creating the Immediate Plan of Care, updating care plans and Certified Nursing Assistant assignment sheets. In addition, the in-service covered timely completion of incident reports and documentation of changes in a resident's condition via the Situation, Background, Assessment, and Response (SBAR) model for documenting, and Physician and Family Notifications. The facility noted no other nurses would be allowed to work without first receiving this training. 10. The Clinical Liaisons (CL), which included Registered Nurses or Licensed Practical Nurses, would review potential resident admissions' for special needs, interventions, or equipment. From the review the facility would plan the resident's admission to ensure the identified needs, interventions or equipment would be in place at the time of admission, which included communicating the resident's needs to the Unit Managers.	F 514		

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11. The Unit Managers would ensure that the interventions, special needs or equipment were in place on admission, the care plan would reflect this information, and staff would be trained on resident care needs.

12. New resident admissions were reviewed in clinical morning meeting by the Unit Managers to ensure assessment, plan of care and documentation had been completed timely and accurately.

13. The facility policies titled: Accident Investigation, dated 06/17/15; Accident Investigation, Cause(s) of Accidents, dated 07/07/15; Interdisciplinary Care Plan, dated 02/26/15, and Resident Transport Policy, dated 08/01/11, were reviewed by the Executive Director, the Assistant Director of Nursing, and the Activities Director on 08/23/15 and it was determined no policy changes were needed.

14. After Resident #26's fall and before continuing to drive to the facility, the Maintenance Director verified the seatbelts and wheelchair restraint systems were in place for two (2) additional residents on the van with Resident #26.

15. The Maintenance Director and all facility personnel authorized to transport residents in the facility's van received training on the facility van's wheelchair lock-down system and on the Resident Transport Policy on 07/28/15. The training was provided by the facility's Activities Director.

16. Facility personnel authorized to transport residents would be retrained quarterly for four (4) quarters and annually, thereafter.

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17. Safe resident transport would be based on the residents' individual needs. The Activities Director would review a resident's assessments and have discussion with the resident's charge nurse regarding the best ways to safely transport the resident.

18. The Human Resources Generalist and the Executive Director reviewed the files of personnel authorized to transport residents in the facility's van to ensure training and competencies were completed. In addition, these employees' files would be audited quarterly for four (4) quarters and then annually.

19. The Quality Assurance Performance Improvement Committee met on 08/23/15 with the following staff persons in attendance: Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Social Worker, Unit Managers, Director of Resident Assessment, Human Resources Generalist, Maintenance Director, Corporate Director of Clinical Education, and the Medical Director to review assessments and monitoring tools.

The State Survey Agency validated the removal of Immediate Jeopardy on 08/29/15 as follows:

1. Interview, on 09/02/15 at 2:20 PM with the Assistant Director of Nursing, revealed Resident #26 was assessed immediately at the time of his/her fall in the van.

2. Review of the Advanced Registered Nurse Practitioner's documented assessment, dated 07/17/15, revealed Resident #26 was assessed by the ARNP.

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3. Interview with the Executive Director, on 09/02/15 at 2:00 PM, revealed the Executive Director was notified of the incident on 07/17/15 by the Assistant Director of Nursing. Review of the Verification of Investigation, revealed investigation of the incident was initiated on 07/17/15.

4. Interview with the Executive Director, on 09/02/15 at 2:00 PM, revealed on 07/17/15 the Executive Director interviewed the Maintenance Director, Assistant Director of Nursing and another resident who had been on the bus, as she initiated an investigation of the incident.

5. Review of the admission assessment titled Clinical Health Status, dated 07/17/15, revealed an assessment of Resident #26 was conducted.

6. Review of the Medication Administration Record and the Clinical Nursing Note for Resident #26, dated 07/17/15, timed 3:30 PM, revealed the resident received Promethazine 12.5 milligrams for nausea and vomiting. Further review of the clinical nursing note revealed the Registered Nurse in charge notified the Advanced Registered Nurse Practitioner of Resident #26's change in condition, at 4:00 PM on 07/17/15, and received an order to transfer the resident to the hospital for an evaluation.

7. Review of an aggregate list of resident falls, titled Total Events by Type, dated 02/22/15 to 08/22/15, revealed the facility's Assistant Director of Nursing identified four (4) residents, in addition to Resident #26, who had fallen within twenty-four (24) hours of their admission to the facility.

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8. Interview, on 08/29/15 at 3:42 PM with the Assistant Director of Nursing, revealed upon review of the records of the four (4) residents who fell within 24-hours of admission, all were non-injury falls and none of the four (4) residents required transfer to the hospital for evaluation. The Assistant Director of Nursing stated she reviewed the time of day each resident was admitted to the facility and their diagnoses. The Assistant Director of Nursing stated she also reviewed the residents' physician orders/prescribed medications, and admission assessments.

Interview, on 08/29/15 at 2:50 PM with the MDS Coordinator revealed she reviewed care plans of the four (4) residents identified with falls within twenty-four (24) hours of admission, and determined the residents' care plans did not need to be updated.

9. Review of the document titled, Summary Report of Meeting: Nursing Lecture, Dated 08/21/15, revealed the facility's Director of Nursing and Assistant Director of Nursing initiated in-service education on 08/21/15 for the licensed nursing staff on resident admission assessments, creating the Immediate Plan of Care (IPOC), updating care plans and updating Certified Nursing Assistant assignment sheets. In addition, the in-service covered timely completion of incident reports and documentation of changes in a resident's condition using the Situation Background Assessment Response (SBAR) model for documentation, and on Physician/Family notifications.

Review of the document titled, Summary Report of Meeting: Nursing Lecture, dated 08/21/15,

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revealed the training was provided to forty-nine (49) licensed nurses and had signed they received the training.

Interview, on 08/29/15 at 1:20 PM with the Executive Director, revealed there were 49 nurses employed by the facility who were currently authorized to work on the nursing units, and all had completed the required training.

Interview on 08/29/15 at 3:05 PM with the Corporate Director of Clinical Services revealed the facility's Director of Nursing and Assistant Director of Nursing had been trained on conducting Resident Admission Assessments, creating the IPOC, updating care plans and Certified Nursing Assistant assignment sheets. The Corporate Director of Clinical Services stated this training also included documentation using the SBAR method when there was a change in a resident's condition, and completion of incident reports.

Review, of the sign-in sheet for the training provided by the Corporate Director of Clinical Services revealed facility's Director of Nursing and Assistant Director of Nursing signed that they attended the training.

Interview, on 08/29/15 at 3:42 PM with the Assistant Director of Nursing, revealed newly hired licensed nurses would receive training on completing admission assessments, creating the IPOC, updating the Certified Nursing Assistant care assignments, documenting via the SBAR when there was a change in a resident's condition, and completing incident reports. Nurses would not work on the nursing units until they had completed the training.

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Interview, on 08/29/15 at 2:32 PM with Licensed Practical Nurse #14, revealed she received training within the past week on admission assessments, completing incident reports and documenting using the SBAR method when there was a change in a resident's condition. Licensed Practical Nurse #14 stated, when she admitted a resident, her responsibilities included obtaining necessary authorizations from the resident or his/her legal representative, conducting a resident assessment, and initiating the resident's IPOC.

Interview, on 08/29/15 at 1:15 PM with the 400 Hallway Unit Manager (UM), revealed she received in-service education in the past week on admission assessments, completing incident reports and documenting using the SBAR method when there was a change in a resident's condition. The 400 Unit Manager stated when a resident was admitted to the 400 Hallway, she reviewed all admission paperwork received from other facilities and reviewed and in-put the orders obtained from the resident's physician. The 400 Hallway Unit Manager stated if not on duty at the time of an admission, she reviewed the resident's paper work and orders, and personally visited the resident upon her return to work.

Interview, on 08/29/15 at 3:13 PM with the 200 Unit Manager, revealed she received recent in-service education on conducting admission assessments, completing SBARs and incident reports. In addition, the 200 Hallway Unit Manager stated the 24-hour shift report was the mechanism used for recording and communicating information about a resident's status, any new care areas, and any changes in a resident's condition over the 24-hour period. The

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200 Hallway Unit Manager stated she reviewed the 200 Hallway 24-hour report every morning to ensure continuity of reporting of the residents' status across all shifts.

Interview, on 08/29/15 at 2:50 PM with the MDS Coordinator revealed she received recent in-service education on care planning for newly admitted residents, and on how nurses were to complete the initial admission assessment packet. The Director of Resident Assessment stated she was also trained on completing incident reports and documenting using the SBAR method in clinical notes. The Director of Resident Assessment/Minimum Data Set Nurse stated if a resident experienced a change in condition, such as a fall, a licensed nurse should assess the resident, put immediate interventions in place to protect and/or treat the resident's injury, if any. The care plan should be updated and the documentation should also include the SBAR and a completed incident report. The Director of Resident Assessment/Minimum Data Set Nurse stated the incident report(s) were later reviewed by the Quality Assurance Committee.

10. Interview, on 08/29/15 at 4:30 PM with the facility's Executive Director, revealed the corporation's clinical liaisons conducted pre-admission assessments for potential residents. The Executive Director stated the clinical liaisons forwarded the assessments to her, and along with the Director of Nursing and/or Assistant Director of Nursing, and the Admissions Director, she reviewed the data to determine the level care the potential resident would require, and any special equipment or arrangements the facility would need to secure prior to the resident's admission.

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11. Interview, on 08/29/15 at 1:15 PM with the 400 Unit Manager, revealed when a resident was admitted to the 400 Hallway, she reviewed all admission paperwork received from other facilities and reviewed and in-put the orders obtained from the resident's physician. She stated the residents' clinical records were reviewed ensure the care plan was initiated, and that the Certified Nursing Assistant Care Record assignments, and the care interventions were communicated to the staff. The 400 Hallway Unit Manager stated if not on duty at the time of an admission, she reviewed the resident's paper work and orders, and personally visited the resident upon her return to work.

12. Review, on 08/29/15 of the Resident Admission Monitoring Tool, revealed the facility had admitted eight (8) residents since 08/26/15. The residents' clinical records were reviewed by the facility's Unit Managers, who signed/dated when they reviewed the residents' records for plan of care, Certified Nursing Assistant Care Record assignments, and for implementation of the care interventions, as planned. According to the Unit Manager's signatures with dates, all eight (8) records had been reviewed for the required components within one (1) day of each resident's admission to the facility.

Interview, on 08/29/15 at 3:42 PM, with the Assistant Director of Nursing revealed she would be responsible for ensuring all components of the admission documentation was completed for newly admitted residents. The Assistant Director of Nursing stated the Unit Managers and the Minimum Data Set Nurses were also responsible for ensuring all necessary admission

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documentation was completed. In addition, the Assistant Director of Nursing stated she would review the new admission audits conducted by the Unit Managers, and these documents would be discussed daily in clinical morning meetings. The Assistant Director of Nursing stated, to date, no corrective action had not been necessary as the admission documentation has been completed for new admissions as required.

13. Interview, on 08/29/15 at 1:20 PM with the Executive Director, revealed she and the Assistant Director of Nursing reviewed following policies 08/23/15: Accident Investigation, dated 06/17/15; Accident Investigation, Cause (s) of Accidents, dated 07/07/15; and Interdisciplinary Care Plan, dated 02/26/15, no changes to the policies were made.

Interview, on 09/02/15 at 2:35 PM, with the Activities Director revealed she reviewed the Resident Transport Policy with the facility's Executive Director, and recently retrained the staff authorized to drive the facility's van.

14. Interview, on 09/02/15 at 3:20 PM with the facility's Maintenance Director, revealed once the Assistant Director of Nursing assessed Resident #26 after his/her fall on the van, he ensured Resident #26's wheelchair lock-down system and seatbelts were secured and fastened. In addition, the Maintenance Director stated he also observed the other two residents on the van to ensure their wheelchairs/safety belts were secured/fastened before moving the van.

15. Interview, on 09/02/15 at 2:35 PM with the Activities Director, revealed on 07/28/15, she retrained the facility's authorized van drivers on

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safe resident transport and proper use of the van's wheelchair lock-down system.

16. Review of the document titled, Quarterly Drivers Files Audit, No Date, revealed the drivers' files would be audited for re-training competencies on 10/28/15, 01/28/16, 04/28/16 and 07/28/16.

17. Interview, on 08/29/15 at 2:50 PM with the Director of Resident Assessment/MDS revealed, on 08/28/15, the Activities Director consulted with the Director Of Assessment/Minimum Data Set Nurse prior to transporting a resident who had a lap tray affixed to his/her wheelchair. The Director of Resident Assessment/Minimum Data Set Nurse stated she referred the Activities Director to Therapy Department as she thought therapy staff could best answer the question related to the resident's wheel chair tray.

18. Interview, on 08/29/15 at 3:22 PM with the Human Resources Generalist, revealed she reviewed the records for all authorized van drivers to ensure their drivers' licenses and Department of Transportation certifications were in-date, and for verification of re-training on the van's wheelchair restraint system. The Human Resources Generalist stated she was assigned to monitor the van drivers records for the required competencies and for verification of quarterly retraining for one year, and thereafter she would conduct an annual review of their records.

19. Review of the document titled, Ad Hoc QAPI, dated 08/23/15, revealed the Executive Director, the Director of Nursing, the Assistant Director of Nursing, the facility's Social Worker, Unit Managers for four (4) of four (4) nursing units, the

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Director of Resident Assessment, the Human Resources Generalist, the Maintenance Director, the Corporate Director of Clinical Education, and the facility's Medical Director attended the QAPI meeting.

Interview with the ADON, on 08/29/15 at 3:42 PM, revealed she would oversee the monitoring that would occur by the Unit Managers and MDS Nurses, for the new admission process, complete all proper documentation, all new admissions will be discussed during the daily clinical meetings, twenty-four hour reports would be reviewed at the clinical meeting. The ADON stated she would also be attending the QA meetings and providing progress of the monitoring process for admissions and changes of condition.

Interview with the Administrator, on 08/29/15 at 4:30 PM, revealed nurses were assigned to monitor tasks described in the AOC to ensure that all residents newly admitted have been assessed and screened by the new process and interventions put in place. The Administrator stated she would have the AOC minder at each morning meeting to review and to check to ensure assigned staff were continuing to monitor for compliance with the plan.